National Library
of Canada

Acquisitions and
Bibliographic Services Branch

395 Wellington Street
Ottawa, Ontario
K1A 0N4

Bibliothèque nationale
du Canada

Direction des acquisitions et
des services bibliographiques

395, rue Wellington
Ottawa (Ontario)
K1A 0N4

Your file Votre référence

Our file Notre référence

NOTICE

The quality of this microform is heavily dependent upon the quality of the original thesis submitted for microfilming. Every effort has been made to ensure the highest quality of reproduction possible.

If pages are missing, contact the university which granted the degree.

Some pages may have indistinct print especially if the original pages were typed with a poor typewriter ribbon or if the university sent us an inferior photocopy.

Reproduction in full or in part of this microform is governed by the Canadian Copyright Act, R.S.C. 1970, c. C-30, and subsequent amendments.

AVIS

La qualité de cette microforme dépend grandement de la qualité de la thèse soumise au microfilmage. Nous avons tout fait pour assurer une qualité supérieure de reproduction.

S'il manque des pages, veuillez communiquer avec l'université qui a conféré le grade.

La qualité d'impression de certaines pages peut laisser à désirer, surtout si les pages originales ont été dactylographiées à l'aide d'un ruban usé ou si l'université nous a fait parvenir une photocopie de qualité inférieure.

La reproduction, même partielle, de cette microforme est soumise à la Loi canadienne sur le droit d'auteur, SRC 1970, c. C-30, et ses amendements subséquents.

Canada

UNIVERSITY OF ALBERTA

A HISTORY OF THE EDMONTON GENERAL HOSPITAL: 1895-1970, "BE FAITHFUL TO THE DUTIES OF YOUR CALLING"

BY

PAULINE PAUL ©

A THESIS SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY.

FACULTY OF NURSING

EDMONTON, ALBERTA
SPRING 1994

National Library
of Canada

Acquisitions and
Bibliographic Services Branch

395 Wellington Street
Ottawa, Ontario
K1A 0N4

Bibliothèque nationale
du Canada

Direction des acquisitions et
des services bibliographiques

395, rue Wellington
Ottawa (Ontario)
K1A 0N4

Your file Votre référence

Our file Notre référence

The author has granted an irrevocable non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of his/her thesis by any means and in any form or format, making this thesis available to interested persons.

L'auteur a accordé une licence irrévocable et non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de sa thèse de quelque manière et sous quelque forme que ce soit pour mettre des exemplaires de cette thèse à la disposition des personnes intéressées.

The author retains ownership of the copyright in his/her thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without his/her permission.

L'auteur conserve la propriété du droit d'auteur qui protège sa thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

ISBN 0-612-11320-5

Canada

UNIVERSITY OF ALBERTA

RELEASE FORM

NAME OF AUTHOR: PAULINE PAUL

TITLE OF THESIS: A HISTORY OF THE EDMONTON GENERAL HOSPITAL: 1895-1970, "BE FAITHFUL TO THE DUTIES OF YOUR CALLING"

DEGREE: DOCTOR OF PHILOSOPHY

YEAR THIS DEGREE GRANTED: SPRING 1994

Permission is hereby granted to the University of Alberta Library to reproduce single copies of this thesis and to lend or sell such copies for private, scholarly or scientific research purposes only.

The author reserves all other publication and other rights in association with the copyright in the thesis, and except as hereinbefore provided neither the thesis nor any substantial portion thereof may be printed or otherwise reproduced in any material form whatever without the author's prior written permission.

#1805, 8210 - 111 Street
Edmonton, Alberta
T6G 2C7

Date: April 11 1994

UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommended to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled A HISTORY OF THE EDMONTON GENERAL HOSPITAL: 1895-1970, "BE FAITHFUL TO THE DUTIES OF YOUR CALLING" submitted by PAULINE PAUL in partial fulfillment of the requirements for the degree of DOCTOR OF PHILOSOPHY.

Janet Ross Kerr
Dr. Janet Ross Kerr Supervisor

Marilynn Wood
Dr. Marilynn Wood

Susan Jackel
Dr. Susan Jackel

Anne Neufeld
Dr. Anne Neufeld

Joan E Lynaugh
Dr. Joan Lynaugh External Examiner
University of Pennsylvania

Date: April 11 1994

Dedicated to the Grey Nuns of Alberta
and to the nurses who studied and worked
at the Edmonton General Hospital.

ABSTRACT

The purpose of this study was to trace the historical development of the Edmonton General Hospital (EGH) between 1895 and 1970. The focus of this project was on the development of nursing services at that hospital. It was acknowledged from the outset that studying the development of these services could not be done without taking into account other aspects of the history of the EGH including the place it occupied in Edmonton and Alberta. Thus, a concerted effort was made to write a context-bound history as reflected in the selected research questions: How did the role of nurses change at the EGH between 1895 and 1970? What was the impact of the Grey Nuns philosophy on patient care delivery and policy making at the EGH? What evidence is there of the impact of societal events on the EGH between 1895 and 1970? What changes at the EGH, between 1895 and 1970 can be attributed to the influence of federal and/or provincial government policies? What were the effects on the hospital of the link between the Grey Nuns and the Franco-Albertan community? Historical methods were used to answer these questions and primary and secondary data were collected, analyzed and organized into a coherent narrative. The results of this study show that nursing and the roles played by nurses greatly changed over the 76 years under investigation and that the hospital evolved from a family like structure to a large quasi-bureaucratic organization. Evidence also indicates that the Grey Nuns who owned and administered the hospital were resourceful women who had the ability to surpass a multitude of problems and difficulties. The results of this investigation show that the fact that the Grey Nuns were Catholic and primarily French Canadian influenced their outlook on life and the way in which they saw their role in the hospital field. Finally, the results presented in this dissertation show that a number of events and government policies influenced the destiny of the institution.

ACKNOWLEDGMENTS

The writer wishes to recognize the assistance of individuals who in a variety of ways facilitated the realization of this project. First and foremost I wish to acknowledge the relentless support and guidance provided by my supervisor, Dr. Janet Ross Kerr, and the much valued assistance of my committee members Dr. Marilynn Wood and Dr. Susan Jackel. I am deeply indebted to them not only because they generously shared their knowledge, expertise and time toward helping me complete this thesis but also because they took at heart my academic and professional development. I am particularly thankful to Dr. Ross Kerr for providing me with additional research opportunities and other experiences which enriched my doctoral studies. I sincerely believe that I could not have had better role models and hope to be able to follow in their footsteps as I embark in a new phase of my career. I am also grateful for the dedication of one of my professors, Dr. Gratien Allaire, who after the completion of courses taken under his direction continued to offer guidance and opportunities for scholarly development.

I wish to sincerely thank the Grey Nuns of Edmonton who always made me feel welcome in their house and especially Sister Fernande Champagne who helped me discover the treasures of the Grey Nuns archives. The countless hours spent working in her company, and the long walks at lunch time will be among the most cherished memories of my doctoral studies. Nursing was often the topic of our conversations and I feel privileged to have been able to talk about my profession with a nurse who has had a long fulfilling career and who also shares my interest in history.

I wish to express my gratitude to my mother who always encouraged me to pursue higher education and did all she could to support my efforts. Warmest thanks also go to my friends and colleagues Wendy Hurtig, Anne Leighton, Birgitte Lund, Kathryn M. King, and Ginette Lemire Rodger for always having been there when I needed them. Finally, I wish to extend my appreciation to my former professors Joan Brodeur and Madeleine Clément who had a profound influence on my academic development and who since the late 1970s have been unconditional friends and supporters.

Financial assistance form the Canadian Nurses Foundation and from the Alberta Foundation for Nursing Research is gratefully acknowledged.

TABLE OF CONTENTS

LIST OF TABLES x

CHAPTER 1. INTRODUCTION AND STATEMENT OF THE PROBLEM . . . 1

- Purpose 2
- Research questions 6

CHAPTER 2. HOSPITAL HISTORIOGRAPHY 8

- Hospital histories 8
- Local hospital historiography 11
- Macro-history of the hospital 13

CHAPTER 3. METHODS 20

- The approach 20
- Data sources 21
  - Primary data 22
  - Secondary data 24
- Data analysis 25
- Limitations 25

CHAPTER 4. HISTORICAL BACKGROUND 27

- Aboriginal health care practices 27
- The origins of nursing and hospital services in Alberta 29
  - The Grey Nuns 29
  - Lay nurses 34
- Alberta prior to gaining provincial status 38
  - The fur trade era 38
  - French Canadians, Métis, and the fur trade in Alberta 39
  - Missionaries and the fur trade 40
  - The Canadian expansionist movement 42
  - Edmonton: the hub of French Canadian settlers 47

CHAPTER 5. THE BIRTH OF AN INSTITUTION: 1894-1895 53

CHAPTER 6. THE TERRITORIAL YEARS: 1895-1904
ADMINISTRATIVE DIFFICULTIES: WHO SHALL BE IN CHARGE
THE SISTERS OR THE PHYSICIANS? 60

Administrative structure of the hospital and of the Grey Nuns' Order . . . 61
Administrative issues . . . 62
    Physicians versus sisters . . . 62
    Other administrative issues . . . 70
        Hospital inspection . . . 73
Sources of financial support . . . 73
    Gifts in kind . . . 74
    Ladies Aid Society . . . 76
    Municipal support . . . 77
    Federal and territorial governments . . . 77
    Patients' contribution . . . 78
Hospital budget . . . 78
CHAPTER 7. A PERIOD OF GROWTH: 1905-1918
IMPROVEMENT OF FINANCES AND EXPANSION . . . 81
Administrative structure . . . 82
Administrative issues . . . 82
    The need to expand and to open a school of nursing . . . 82
    World War I . . . 85
Sources of financial support . . . 86
    Gifts in kind and citizen's donations . . . 86
    Ladies Aid Society . . . 89
    Municipal support . . . 89
    Provincial and federal support . . . 90
Hospital budgets . . . 90
CHAPTER 8. ADAPTING TO THE ENVIRONMENT: 1919-1938
STANDARDIZATION AND ECONOMIC PRESSURES . . . 97
Administrative structure . . . 97
Administrative issues . . . 97
    Construction plan . . . 97
    Hospital standardization movement . . . 98

Background 98
The Catholic Hospital Association (CHA) 100
The Catholic Hospital Association and the American College of Surgeons 101
Grey Nuns' participation 102
Alberta and the EGH 103
The economic depression 106
Unemployment 106
Racial tension 106
The Edmonton Hospitalization Group Plan 108
Provincial politics 108
The effect of the depression on the EGH 109
The search for contracts 109
Creation of an advisory board 110
The tuberculosis contracts 111
Sources of financial support 113
Gifts in kind and citizens donations 113
Municipal support 113
Provincial and federal support 114
Hospital budgets 114
CHAPTER 9. FROM WAR TO PROSPERITY: 1939-1957 TOWARDS A NEW HEALTH CARE SYSTEM 121
Administrative structure 121
Administrative issues 122
The 1940 building 123
The temporary ward of 1948 130
The 1953 building and the end of the tuberculosis era 130
Hospital and health insurances 134
World War II 138
Sources of financial support 141

Hospital budgets 141

CHAPTER 10. THE HEALTH INSURANCE ERA: 1958-1970 144

Administrative structure 144

Administrative issues 147

The increased participation of the state 147

Sisters' Equity 148

Sources of financial support and hospital budgets 148

CHAPTER 11. THE GREY NUNS - WHO WERE THEY? 150

Place of birth 151

Nationality 154

Parental occupation 160

Occupation of mothers 161

Occupation of fathers 162

Family size 167

Relatives in religious life 169

Joining the Order 174

Education of the sisters 179

Education of nurses 181

A nursing diploma is not the end 185

Sisters occupations 189

Superiors and directors 194

Longevity 198

CHAPTER 12. THE WORKFORCE OF THE EDMONTON GENERAL HOSPITAL. 205

Evolution of the hospital workforce 205

The Grey Nuns 205

Duration of hospital service by the Grey Nuns 205

Sisters' occupational diversity through time 208

Lay staff 210

Nursing staff 213

Support staff 221
Technical workers 223
Pharmacists, dieticians and physiotherapists 224
Physicians, interns and residents 226
Chaplains 227
Collective bargaining 227
A climate leading to collective bargaining 228
Employment benefits of the 1940's and the first two unions 232
Engineers 234
Concerns of the Catholic clergy 235
Support staff union, local 123 235
Negotiations of the engineers' union and of Local 123 . . . 237
Collective bargaining in nursing 240
The double standard 243
The work family 245
Employees' Newsletter 246
The Christmas season 246
Christmas celebrations 246
Gifts from physicians 247
Long service awards 248
Other social activities with the sisters 249
CHAPTER 13. THE EGH SCHOOL OF NURSING: 1908-1973 251
The origins of graduates of the school 252
Place of origin of the graduates of the EGH School of Nursing . . 254
Graduates from Alberta 255
Graduates from Saskatchewan 260
Graduates from British Columbia 261
Graduates from other provinces or countries 261
French Canadian graduates 262
Franco-Albertans 262

        Fransaskoises 265
        Other provinces or country of origin 265
    French Canadian graduates over time 265
    Graduates of Eastern-European origin 267
    Graduates from Edmonton 268
The growth of the EGH School of Nursing 273
Attrition at the EGH School of Nursing 276
    Withdrawals over time 276
    Causes of withdrawal 279
        Unsatisfactory performance 281
        Illness 283
            Types of illness 285
        Dislike nursing 286
        Marriage 287
        Personal reasons 288
    Patterns of causes of withdrawal over time 289
    Relationship between times of withdrawal, periods of time
    and causes of withdrawal 293
The education and life of nursing students 294
    Schedules of work and leisure 295
        Monetary allowance 301
    Education and life from 1908 until 1942 302
        Curriculum and instruction 302
        Leisure activities 311
            Graduation 312
        The transmission of Catholic values 313
        The faculty 315
        The 1929 conflict 315
    Education and life from 1943 to 1967 324
        Curriculum and instruction 325

Leisure and recreational activities . . . 332

Graduation . . . 333

The transmission of Catholic values . . . 333

The faculty . . . 334

The *Collège Saint-Jean* era, 1968-1972 . . . 336

CHAPTER 14. RESPONDING TO THE HEALTH CARE NEEDS OF THE POPULATION . . . 355

Government health care policies . . . 355

The Liberal Party, 1905-1921 . . . 356

The United Farmers of Alberta, 1921-1935 . . . 358

The Social Credit Party, 1935-1971 . . . 361

Patient care statistics . . . 367

Admissions between 1913 and 1967 . . . 367

Deaths between 1913 and 1967 . . . 369

Tuberculosis statistics . . . 370

Obstetrical statistics . . . 372

Number of X-Ray and laboratory tests over time . . . 372

Responding to epidemics and infectious diseases . . . 375

Smallpox . . . 375

Spanish influenza . . . 376

Tuberculosis . . . 378

Poliomyelitis . . . 381

Infection control . . . 383

The development of specialized services . . . 385

The new departments and programs . . . 386

The emergency department . . . 386

Premature babies unit . . . 388

Surgical recovery room . . . 389

The care of diabetic patients: a model of out-patient services . . . 390

Civil defense and casualty alert plan 393

The first intensive care unit 394

The department of nursing 395

The relationship between medicine and nursing 397

The delegation of medical acts 397

Standing orders 399

CHAPTER 15. THE EGH AS A CATHOLIC INSTITUTION 404

The Grey Nuns 404

The legacy of Marguerite d'Youville 404

The daily religious life of the sisters 410

Religion and patient care 412

Charity 420

Religion and lay nurses 422

The Catholic morals 426

Religion and physicians 428

CHAPTER 16. THE GREY NUNS, THE EGH, AND THE FRANCO-ALBERTAN COMMUNITY 430

The social life of the Grey Nuns 430

Festive days 430

Christmas 430

New Year's Day 431

Epiphany 432

Saint-Blaise's Day 432

Saint John the Baptist's Day 433

Saint-Catherine's Day 434

Regular leisure activities 435

Social activities with other religious orders 436

1895 to 1950 437

1950 to 1970 437

The Franco-Albertan staff of the EGH 438

The Franco-Albertan question at the EGH 440
    The Grey Nuns, nationalism, and the ACFA 441
    The role of the EGH for the Franco-Albertan population of the Edmonton area 442
CHAPTER 17. CONCLUSION 447
How did the role of nurses change at the EGH between 1895 and 1970? 447
What was the impact of the Gey Nuns philosophy on patient care delivery and policy making at the EGH? 449
What evidence is there of the impact of societal events on the EGH between 1895 and 1970? 451
What changes at the EGH, between 1895 and 1970 can be attributed to the influence of federal and/or provincial government policies? 452
What were the effects on the hospital of the link between the Grey Nuns and the Franco-Albertan community? 453
BIBLIOGRAPHY 456

LIST OF TABLES

1. Value of gifts in kind, 1896-1900 74
2. Value of gifts received during the 1910's 87
3. Christmas gifts 1909 to 1915 88
4. Operating budgets of 1913-1914, 1916-1917 and 1918-1919 91
5. Assets and liabilities in 1914, 1917, and 1919 91
6. Creditors in 1917 and 1919 92
7. Income in 1913-1914, 1916-1917 and 1918-1919 94
8. Expenses in 1913-1914, 1916-1917 and 1918-1919 95
9. Christmas gifts for selected years between 1926 and 1938 113
10. Operating budgets of 1920-1921, 1925-1926, 1930-1931 and 1935-1936 . . . 115
11. Assets and liabilities in 1921, 1926, 1931 and 1936 116
12. Creditors 1921, 1926, 1931 and 1936 117
13. Income in 1920-1921, 1925-1926, 1930-1931 and 1935-1936 118
14. Expenses in 1921-1921, 1925-1926, 1930-1931 and 1935-1936 119
15. Expenses in 1953 142
16. Place of birth of the Grey Nuns who worked at the EGH 152
17. Places of origin of the sisters born in Alberta 153
18. Number and percentage of sisters by nationality 155
19. Number and percentage of French Canadians by place of origin 156
20. Number and percentage of sisters from other nationalities than French Canadian by place of origin 157
21. Number of French Canadian sisters and of sisters of other nationalities and percentage each group represents for each place of origin 158
22. Places of origin by nationalities other than French Canadian 159
23. Total number and percentages of fathers in each occupational group 163
24. Number and percentage of French Canadian fathers in each occupational group 164

25. Number and percentage of members of each occupational group for Alberta, Quebec, Saskatchewan and the USA 164
26. Number and percentage of French Canadian fathers in each occupational group for Alberta, Quebec, Saskatchewan and the USA 165
27. Number and percentage of fathers of other nationalities then French Canadian in each occupational group 166
28. Number of families by range of number of children 168
29. Summary of family statistics 169
30. The Grey Nuns and their siblings in religious life 170
31. Relatives other than siblings in religious life 171
32. Mean age at entrance to novitiate by decade of entry 176
33. Number of subjects by number of years of novitiate by decade 177
34. Mean number of years of novitiate by decade of entry 178
35. Number of years of education by decade of birth 179
36. Average number of years of education by occupation and by decade of birth 180
37. Number and percentage of subjects by schools of nursing 183
38. Number and percentage of nurses born per decade 184
39. Number of nurses by place of origin and school location 185
40. Number of sisters with university education by decade of birth 187
41. Number and percentage of sisters by nationality by occupation 192
42. Number and percentage of sisters by place of origin by occupation 193
43. Sisters' occupations by fathers' occupations 194
44. Occupations of the fathers of the superiors by place of origin 196
45. Nationality of the directors by place of origin 197
46. Number and percentage of births by generation and life expectancy at birth by generation 199
47. Mean age at death and mean age in 1992 201
48. Percentage of survivors at age 65 by generation from 1841 to 1880 201
49. Percentage of survivors at age 65 by generation from 1881 to 1910 202
50. Number of sisters by range of number of years worked at the EGH 206

51. Number of years spent in leadership roles 207
52. Sisters' occupational distribution through time 208
53. Statistics on the number of sisters by time period 209
54. Statistics on EGH staff including lay employees and nuns by time period . . . 212
55. Statistics on EGH staff including lay employees nuns and student nurses by time period 212
56. Statistics on the EGH staff including employees nuns and all students by time period 212
57. Comparison of the nursing and support staff workforces 213
58. Mean number of support staff by gender and by time period 222
59. Places of origin of the graduates of the EGH school of nursing 255
60. Regions of origin of graduates of Alberta 257
61. Alberta communities generating ten or more graduates 258
62. Places of origin of the French Canadian graduates 262
63. Alberta regions of origin of French Canadian graduates 263
64. Most common places of origin of French Canadian graduates 264
65. Number and percentage of French Canadian graduates by time period 266
66. Number and percentage of graduates from Edmonton by time period 269
67. Percentage of graduates from Edmonton between 1924 and 1962 270
68. Statistics about graduates by time period 273
69. Number and percentage of withdrawals per year in function of enrolment by time period 277
70. Number and percentage of withdrawal per year of study by time period . . . 277
71. Number and percentage of withdrawal by causes of withdrawal 282
72. Number and percentage of withdrawal by cause per period of study 282
73. Percentage of withdrawals attributed to an unsatisfactory performance for selected years 283
74. Percentage of withdrawals attributed to illness for selected years 284
75. Available diagnosis of students who withdrew because of illness 286
76. Percentage of withdrawals attributed to a dislike of nursing for selected years 287

77. Percentage of withdrawals attributed to marriage for selected years 288
78. Percentage of withdrawals attributed to personal reasons for selected years . . 289
79. Number and percentage of withdrawals by cause of withdrawal by time period 290
80. Number and percentage of withdrawal by unsatisfactory causes by time period 291
81. Number and percentage of withdrawals because of marriage in each half of the program by time period 294
82. Nursing students' work schedules over time 296
83. Nursing students' leisure time and holidays over time 297
84. Admission statistics between 1913 and 1967 368
85. Number of deaths and percentage of deaths based on the number of admissions by time period 369
86. Tuberculosis statistics 371
87. Statistics on x-ray and laboratory examinations for selected years 374

CHAPTER 1

INTRODUCTION AND STATEMENT OF THE PROBLEM

The emergence of organized nursing services in Alberta can be attributed to three members of the Grey Nuns' Order of Montreal. In 1859, Sisters Emery, Lamy and Alphonse established their first mission at *Lac Sainte-Anne*. This event marked the beginnings of an ever-present involvement of the Grey Nuns in the provision of health care services to residents of the region of the Northwest Territories known today as the province of Alberta. That a group of French Canadian nuns came as far west as Alberta in the mid-nineteenth century corresponded to a tradition of services at the 'frontier' established by female religious orders from France who had settled at Quebec in 1639. French female religious orders were at the forefront of life in New France from the outset for reasons which were both evangelistic and humanitarian in nature.

In 1737, less than a century after the arrival of the first nursing sisters, Marguerite d'Youville established the Sisters of Charity of Montreal commonly known as Grey Nuns of Montreal. By taking over the administration of the "Hôpital Général de Montréal", d'Youville and her group officially engaged in the care of the poor and the sick. Importantly, by requesting a non-cloistered sisterhood charter, d'Youville gave the members of her order the opportunity to provide service outside the hospital walls. It is known that from the outset the Grey Nuns visited the sick in their homes and provided care to immigrants afflicted with contagious diseases. Canadian nursing historians have given credit to the Grey Nuns for having been the first visiting or community health nurses of the country.[1]

The Grey Nuns' involvement in western Canada originated at St-Boniface in 1844 where they established a mission at the request of Bishop Provencher.[2] The Sisters soon gained an enviable reputation as the quality of their work in the Red River area attested to their ability to meet the diverse needs of the indigenous and Métis populations of the region. The Grey Nuns also demonstrated that they were resourceful women who could survive under the difficult conditions which characterized remote and isolated areas. It is therefore far from surprising that in 1857, Father Lacombe and Bishop Taché requested the assistance of the Order for their mission at *Lac Sainte-Anne*. Fifty years after the arrival of the first three sisters, the community had established fifteen missions within the large territory comprising Alberta, Saskatchewan, and the current Northwest territories. Some of these establishments are still prospering today. Such is the case of the Edmonton General Hospital founded in 1895. Indubitably, the Edmonton General Hospital is one of the most important legacies of the Grey Nuns in Alberta. As such its history could be likened to a treasure chest containing an important chapter of the history of nursing and health care services provided by the Grey Nuns in Alberta.

---

[1] John M. Gibbon and Mary S. Mathewson, ***Three centuries of Canadian nursing***, (Toronto: The MacMillan Company of Canada, 1947), 46; Margaret M. Allemang, "Development of community health nursing in Canada." In ***Community health nursing in Canada***, ed. Miriam Stewart, Jean Innes, Sarah Searl, and Carol Smillie, (Toronto: Gage Educational Publishing Company, 1985), 4.

[2] Estelle Mitchell, ***Les Soeurs Grises de Montréal à la Rivière Rouge 1844-1984***, (Montreal: Editions du Méridien, 1987).

Purpose

The purpose of this study is to trace the historical development of the Edmonton General Hospital (EGH) between 1895 and 1970. The focus of this project is on the development of nursing services at that hospital. However, it was acknowledged from inception that studying the development of these services could not be done without taking into account other aspects of the history of the EGH. In particular, it was recognized that a great deal of attention had to be given to the Grey Nuns as a group and as individuals because they exercised leadership in all spheres of activity of the hospital, and because they had a primary and profound influence on the nursing care component of the institution. As will be seen, the sisters were "faithful to the duties of their calling"[3] and expected nursing students, nurses and all others who worked at the EGH to respect the ethical principles and precepts of their chosen profession.

---

[3] This expression, which is part of the title of this dissertation, was inspired by the spiritual testament of Marguerite d'Youville who stated in 1771: "My dear Sisters, be constantly faithful to the duties of the state you have embraced. Walk always in the path of regularity, obedience, and mortification; but above all, let the most perfect union reign among you." Les Soeurs de la Charité de Montréal, ***Les Soeurs Grises***, (Montreal: author, 1987), 43.

As revealed in the literature, most hospital histories have only paid lip service to nursing care even though nurses have traditionally constituted the most significant group of health care professionals within these institutions. Considering the fact that a large proportion of hospitals were first established and operated by nursing religious orders, biases such as this reflect a misrepresentation of the past. It was particularly disconcerting to note that even in Quebec where religious orders have been involved in hospital care for more than three hundred years, few hospital historians have explicitly recognized the contribution of nursing religious orders to the development of these institutions. Not surprisingly, it seems that the first authors who acknowledged this contribution were members of nursing religious orders.[4] Although interest in the topic seems to be growing in light of a small body of substantive work that has been produced in the last few decades,[5] it appears that there is still a modicum of research being conducted in the area especially in respect of religious nursing orders interventions outside of Québec.

The small number of publications about the nursing carried out by female religious orders is associated with factors ranging from the place of women in historical writing to other characteristics of Canadian historiography. Historical work relating to female religious orders in general has primarily been undertaken by authors of French Canadian origin. This is understandable considering the origins of the congregations and the historiographical tendencies found in this country. Most of these orders were Roman Catholic and French Canadian organizations and accordingly they have been studied by French Canadians.[6] This situation reflects the Canadian historical tradition which can be divided into two branches corresponding to the two dominant cultural groups. The words of Berger give a vivid description of this phenomenon:

---

[4] The books of Sister Fauteux and Sister Mondoux were likely among the first Canadian hospital histories in which nursing was formally recognized as a vital service of the institution. Sister Albina Fauteux, ***Love spans the century***, 1915 original translated by Antoinette Bézaire, (Montreal: Meridian Press, 1987); Sister Mondoux, ***L'Hôtel-Dieu premier hôpital de Montréal***, (Montreal: Thériens Frères, 1942).

[5] Micheline D'Allaire, ***L'Hôpital Général de Québec 1692-1764***, (Montréal: Collection Fleur de Lys, Fides, 1971); Diane Bélanger and Lucie Rozon, ***Les religieuses au Québec***, (Montreal: Librairie Expression, 1982); Normand Perron, ***Un siècle de vie hospitalière au Québec. Les Augustines de l'Hôtel-Dieu de Chicoutimi 1884-1984***, (Quebec: Presses de l'Université du Québec, 1984); François Rousseau, ***L'oeuvre de chair en Nouvelle-France. Le régime des malades à l'Hôtel-Dieu de Québec***, (Quebec: Cahier d'histoire de l'Université Laval, Presses de l'Université Laval, 1983); and Nicole Laurin, Danielle Juteau and Lorraine Duschene, ***A la recherche d'un monde oublié, les communautés religieuses de femmes au Québec de 1900 à 1970***, (Montreal: Le Jour, 1991).

> In historical writing, as in other aspects of the life of two peoples, the metaphor of the two solitudes seemed appropriate. Even a cursory glance at the actual development of French-Canadian historical thought reveals the extent to which it diverged from English-Canadian problems and concerns."[7]

Thus the interests of each group have differed and themes of historical investigations in each group have reflected this. It is also apparent that contemporary historical writing in Quebec, where the majority of historians of French Canadian background live, is centred on the history of the province. Similarly, English Canadian historians have been more preoccupied by the history of the geographical areas which can be labelled as English Canadian. It is remarkable that within each group little emphasis has directed towards the study of minority groups.[8] The above tendencies have had direct implications for the history of religious orders in Canada. Until recently, the work of religious orders outside Quebec had been almost ignored. The absence of serious historical research about the Grey Nuns in Alberta illustrated this point. As French Canadians in the West they were part of the ignored and invisible minority and, since they were outside Québec, they fell beyond the common geographical boundaries of Quebec historiography. The gender issue also significantly contributed to the marginal level of interest in women's religious orders. Not long ago, studying the history of women or of women's groups was outside the realm of "historical orthodoxy". It is important to recall that prior to 1977, women's history was never a session topic at the Canadian Historical Association meetings.[9] To make matters worse, the place given to nursing in the field of the history of women has also been marginal. Daigle's words confirm observations made by the writer: "L'histoire du travail féminin a pour ainsi dire laissé dans l'ombre celle de la profession d'infirmière. Qui plus est, l'histoire syndical elle-même a négligé cette catégorie de travailleuse."[10] It may be suggested that one of the best ways to deal with these historiographical issues and to redress the state of historical knowledge about religious nursing orders in minority situations is to study the work of orders who lived in that minority context.

---

[6] French Canadian is used in a wide sense and includes here religious orders originating from France.

[7] Carl Berger, ***The writing of Canadian history. Aspects of English-Canadian historical writing 1900-1970***, (Toronto: Oxford University Press, 1986), 181.

[8] Recent work seems to reflect a tendency to remedy to this situation. For example, the second edition of *L'histoire des femmes au Québec*, gives more information about members of minority groups than did the first edition. It is notable that Margaret Conrad had questioned the place given to minorities in the first edition of this book. Micheline Dumont, Michèle Jean, Marie Lavigne and Jennifer Stoddart, ***L'Histoire des femmes au Québec***, (Louiseville: Imprimerie Gagné, 1982); Ibid., 2d, ed. (1992); Margaret Conrad, "The re-birth of Canada's past: a decade of women history," In ***Contemporary approaches to Canadian history***, ed. Carl Berger, (Toronto: Copp Clark Pitman Limited, 1987), 184; In Alberta, Howard Palmer and Tamara Palmer have shown unusual awareness in the roles played by minority groups in the province. See: Howard

The results of this study confirm the position that a historical analysis of the development of nursing at a selected institution can increase the knowledge and understanding of the history of nursing in Alberta as well as provincial history in general.

Palmer and Tamara Palmer, ***Peoples of Alberta - Portraits of cultural diversity***, (Saskatoon: Western Producer Prairie Books, 1985); Ibid., ***Alberta a new history***, (Edmonton: Hurtig Publishers, 1990).

[9] Conrad, Ibid., 181.

[10] Quote translation: "It may be stated that the field of history of women's work has left in the dark the history of the nursing profession. Further, collective bargaining history has neglected this group of workers." Joanne Daigle, "L'éveil syndical des 'religieuses laïques': l'émergence et l'évolution de l'Alliance des Infirmières de Montréal, 1946-1966," In ***Travailleuses et féministes - Les femmes dans la société québécoise***, ed. Marie Lavigne and Yolande Pinard, (Montreal: Boréal Express, 1983), 115.

As proposed by Rosner, Perron, and Granshaw, institutions are a mirror image of the society in which they are created.[11] Rosenberg described hospital history in the following terms: "... a revealing microcosm of the changes that have transformed society."[12] Much can be learned about a society through the study of an institution such as a hospital. Conversely, it may also be suggested that the study of any aspects of a hospital history can only be enhanced by considering the symbiotic relationship between hospital and community. Thus, a concerted effort was made to write context-bound history as reflected in the selected research questions.

Research Questions

1- How did the role of nurses change at the EGH between 1895 and 1970?

2- What was the impact of the Grey Nuns' philosophy on patient care delivery and policy making at the EGH?

3- What evidence is there of the impact of societal events on the EGH between 1895 and 1970?

4- What changes at the EGH, between 1895 and 1970 can be attributed to the influence of federal and/or provincial governments' policies?

5- What were the effects on the hospital of the link between the Grey Nuns and the Franco-Albertan community?

The purpose of this chapter was to provide a brief overview of the nature of this study. The following chapters consist of a topical and chronological historical study of the EGH. In Chapter 2, the current state of hospital historiography is presented in order to provide a background to Chapter 3 which includes an explanation of the research methods used in this study and of the limitations inherent in the project. The purpose of Chapter 4 is to provide a summary of relevant aspects of the history of the Northwest

---

[11] David Rosner, ***A once charitable enterprise. Hospitals and health care in Brooklyn and New York, 1895-1915***, (Cambridge: Cambridge University Press, 1982); Normand Perron, ***Un siècle de vie hospitalière***; Lindsay Granshaw, "Introduction," in ***The hospital in history***, (New York: Routledge, 1989).

[12] Charles E. Rosenberg, ***The care of strangers. The rise of America's hospital system***, (New York: Basic Books Inc. Publishers, 1988), ix.

Territories and of Canada prior to the establishment of the EGH, while in Chapter 5 the goal is to indicate how the hospital came into being. Chapters 6 to 10 encompass the administrative history of the hospital. The subject is presented using five time periods in which administrative structure and issues are examined as well as sources of funding, budgets, and financial statements. Chapters 11 to 13 are devoted to the people who worked and studied at the EGH. The purpose of Chapter 11 is to shed light on the origins of the Grey Nuns who worked and lived at the EGH. In Chapter 12, the evolution of the hospital workforce is studied, including the development of collective bargaining units. Chapter 13 encompasses a description of the geographical and ethno-cultural origin of the nursing students, as well as an analysis of the evolution of the school of nursing. Chapters 14, 15, and 16 are devoted respectively to patient care, to the Catholic nature of the hospital, and to the link which existed between the Grey Nuns and the Franco-Albertan community. Finally, in Chapter 17, the research questions are revisited and conclusions drawn from the results and analysis presented in previous chapters.

CHAPTER 2

HOSPITAL HISTORIOGRAPHY

The purpose of this chapter is to examine the field of hospital historiography. The intent is also to present the strengths and weaknesses which have been identified by the writer based in part on the literature. The chapter is divided into three sections. The first one is devoted to the writing of hospital histories in general, the second to what has been written about Edmonton hospitals, and the third to what could be considered macro-history of the hospital. By this is meant the field of research in which historians propose global models about the development of the modern hospital in North America.

Hospital histories

Numerous hospital histories have been written to date undoubtedly because the hospital was considered sufficiently important to be worthy of investigation. However, as noted by Guy and Connor, authors of hospital histories approached their topics from a variety of backgrounds and focus.[13] Most histories have been written by lay historians, physicians and administrators, few professional historians having worked in this field of research. This can be explained at least in part by the North American context in which social history gained acceptance relatively late. In general, the educational preparation of hospital historians has shaped their approaches to their studies as well as the degree to which they systematically apply historical methods in their work. A majority of the writers of hospital histories have or had limited historical preparation. Ludmerer found that "... most [hospital histories] are simple chronologies, devoid of explanations or interpretation. Many are little more than collective biographies of anyone ever associated with the institution."[14] A large number of hospital histories have been written by physicians. Granshaw found that hospital histories written by these individuals tended to focus on medical staff only as if no other significant group of individuals contributed to the growth and development of these institutions.[15]

---

[13] John R. Guy, "Of the writing of hospital histories there is no end," ***Bulletin of history of medicine***, 59 (1985): 415-420; J.T.H. Connor, "Hospital history in Canada and the United States," ***Canadian Bulletin of Medical History***, 7, 1 (1990): 93-104.

[14] Kenneth Ludmerer, "Writing the history of hospitals," ***Bulletin of the history of medicine***, 56 (1982): 107.

In order to qualify as a hospital history, a piece of work should at least provide evidence which demonstrates the commitment of the writer to fundamental historical tenets or principles. Collectively, analysts of the historical literature about hospitals have demonstrated that more often than not, writers of hospital histories have violated these principles or have fallen short of providing information which would allow the reader to judge whether or not the principles were respected. Ludmerer rightly suggests that authors should delineate the major forces shaping the development of the institution under analysis. For him,

> such an approach demands an awareness of development in medical science and practice, the growth of the other professional groups, public attitudes towards the medical profession and towards disease, the movements in social welfare and social reform, the changing responsibility of government, the role of philanthropy, and events particular to the community under consideration.[16]

In a review of nine hospital histories written in the United States and United Kingdom, Guy outlined similar weaknesses to those identified by the aforementioned author. For him, hospital historians are often afflicted by "tunnel-vision".[17] Similarly, Granshaw found that hospital historians have barely scratched the surface of the significance of the hospital in society.[18] Shortt and Risse both stated that most hospital histories are chronological narratives that rarely include analysis.[19] In reading hospital histories it was noted that authors have rarely attempted to relate the history of the institution under scrutiny to advances in health sciences or to local community events. Another common flaw is that authors fail to document the location of records to which they are referring. Guy admitted that Ludmerer's conclusions on the state of hospital historiography were pertinent. However, he correctly pointed to the fact that the audience for whom a hospital history is written should be considered. A large number of histories are written for the people of a local area and Guy suggests that most authors were not "... setting out to make a contribution to 'the history of medicine' and they would be the first to admit they were not competent to do so."[20] Similarly, Connor stated that the lack of bibliographies and/or absence of mention of research materials should be cause for alarm in academia but perhaps can be overlooked if the purpose is to serve a general audience.[21] Unfortunately, while being correct in recognizing the need for better documented hospital histories, Connor does not seem to have taken into account a recent piece of French Canadian historiography that could have given him hope about the development of the field.

---

[15] Lindsay Granshaw, "Introduction," In ***The hospital in history***, ed. Roy Porter and Lindsay Granshaw, (New York: Routledge, 1989), 1; The writer has reached the same conclusions and relevant examples are presented in the next section.

[16] Ludmerer, "Writing the history of hospitals," 107.

[17] John R. Guy, "Of the writing of history there is no end." ***Bulletin of the history of medicine***, 59 (1985): 416.

[18] Granshaw, "Introduction", 1.

[19] S.E.D. Shortt, "The Canadian hospital in the nineteenth century: A historiographical lament," ***Journal of Canadian Studies***, 18, 4 (1983-1984): 4; Guenter

In fact, Perron's history of the *Hôtel-Dieu of Chicoutimi* meets the criteria enumerated by Ludmerer, Guy, and Connor.[22] In his monograph, Perron integrated the local history and provincial policies into the history of the hospital. Changes in the population served by the hospital were documented and a large portion of his work was devoted to the Augustinian Sisters who were the first administrators of the hospital. An attempt was also made to document the relationships of the sisters with physicians and

---

B. Risse, "Hospital history: new sources and methods." In ***Problems and methods in the history of medicine***, ed. Roy Porter and Andrew Wear, (London: Croom Helms Editors, 1987), 175.

[20] Guy, "Of the writing of hospital histories there is no end," 419.

[21] Connor, "Hospital history in Canada and the United States," 96.

[22] Normand Perron, ***Un siècle de vie hospitalière au Québec, les Augustines de l'Hôtel-Dieu de Chicoutimi, 1884-1984***, (Chicoutimi: Presses de l'Université du Québec, 1984).

hospital employees in the light of the changing roles of the hospital and of advances in health care practices and technologies. Perron acknowledged sources of information, the location of archival materials and included an impressive bibliography. Interestingly, Perron indicated that he wrote this history to commemorate the centenary of the hospital at the request of the Augustinian Sisters. The reader is informed that the sisters had requested a "scientific study" which would recognize the religious aspects, the evolution of the institution and the integration of the hospital in the Chicoutimi area.[23] It appears that this author met the challenge and succeeded in writing not only an interesting but also a methodologically impeccable history. Even if footnotes are numerous, it is obvious that the sisters did not think that they would be a major deterrent for lay readers.

Local Hospital Historiography

Local hospital histories were reviewed in light of the methodological considerations presented in the previous section. Special attention was paid to determine the extent to which the role of nursing in the development of these institutions had been described and analyzed. Available histories of institutions of the local area including the University of Alberta Hospitals, the Alberta Hospital, the Royal Alexandra Hospital, the Misericordia Hospital, and the Edmonton General Hospital were reviewed.

Two histories of the University of Alberta Hospitals have been written. The McGugan and Vant and Cashman histories[24] are narrative, include limited analysis, take minimal account of local and provincial history, and do not directly acknowledge sources of references. In both cases and especially in McGugan's work, nursing contributions to the hospitals development were hardly mentioned. McGugan wrote three and a half pages on nursing, of which one did not even relate to the University of Alberta Hospitals. Both histories place considerable emphasis on individual physicians and their work. In fact McGugan's history consisted of an enumeration of physicians' biographical sketches and did not include any discussion explaining how physicians worked together and with other professionals of the institution.

---

[23] Ibid, xiii.

[24] Angus McGugan, ***The first fifty years. A history of the University of Alberta Hospitals 1914-1964***, (Edmonton: The University of Alberta Hospitals, 1964); J. Ross Vant and Tony Cashman, ***More than a hospital, University of Alberta Hospitals 1906-1986***, (Edmonton: University of Alberta Hospitals Board, 1986).

Abercrombie's narrative history of the Alberta Hospital, Edmonton mental health institution, included some considerations about nursing practice.[25] However, most of the discussion about nursing related to the school of psychiatric nursing and to present or more recent (after 1970) nursing developments. It is likely that the school records were more meticulously kept than other records regarding nursing, and that information on more recent nursing development were more readily available.

Dorward and Tookey wrote a history of the Royal Alexandra Hospital and of its School of Nursing.[26] This history was published by the Alumnae Association of the Royal Alexandra Hospital School of Nursing. Understandably the main focus of the authors is on the development of the school. Dorward and Tookey recognized the context in which the school was developed and gave some attention to events that marked society in general. For example, changes associated with the 1930's economic depression and World War II were documented. However, as was the case for all the above histories, data sources and references were not provided.

Of all local histories, Gilpin's history of the Misericordia Hospital is the most comprehensive and scholarly.[27] Written for the eighty-fifth anniversary of the institution, his account provided excellent background information on the development of Edmonton throughout the period under study. The author also outlined the birth of the city and the role of the Roman Catholic Church in nineteenth century Alberta. The leadership displayed by the Sisters of Misericordia was acknowledged and although information about nursing was quite limited, the profession was portrayed as a prominent force in the institution. Lastly, although references were not specifically identified within the text, a list of the primary and secondary sources was provided at the end of the book.

---

[25] Sheila Abercrombie, ***Alberta Hospital Edmonton, 1923 to 1983. An outline of history to commemorate the 60th anniversary***, (Edmonton: Alberta Hospital and ABC Press, 1983).

[26] Christina Dorward and Olive Tookey, ***Below the flight path***, (Edmonton: Commercial Printers Limited, 1968).

[27] John Gilpin, ***The Misericordia hospital, 85 years of service in Edmonton***, (Edmonton: Misericordia Hospital, 1986).

Finally, of particular relevance to this study is the work of Sister Ell who wrote a forty page booklet on the history of the Edmonton General Hospital to commemorate the ninetieth anniversary of this institution.[28] This booklet was obviously designed to satisfy the curiosity of a lay audience and although informative, it cannot be considered a true history of the EGH.[29] The booklet includes more pictures than text and the content only gives an overview of selected events.

In summary, the review of local hospitals histories indicated that most of the weaknesses identified earlier are present in the local historiography. It also added strength to the thesis that this area of research needed to be further explored. Considering that Sister Ell's booklet stands as the only document published about the first hospital of Edmonton, and that the EGH played and continue to play an important role in providing health care services to Edmontonians, it was apparent that a major historical study of this institution was needed.

Macro-history of the hospital

It appears that to date, Agnew produced the only integrated history of Canadian hospitals.[30] This author studied the evolution of Canadian hospitals between 1920 and 1970. Although his study is primarily narrative and does not provide sources of references in a consistent manner, it gives a unique account of the development of hospital care in Canada during the selected fifty years. As past executive director of the Canadian Hospital Association, Agnew was in an advantageous position to write such a history. Yet, his analysis of the general historical context is superficial and he neglected the role played by nurses.

---

[28] Ann Ell, ***Edmonton General Hospital, 90th anniversary publication***, (Edmonton: Edmonton General Hospital, 1985).

[29] It must be noted that Sister Ell wrote a more indepth document which unfortunately was never published. This document has been preserved at the ASGME.

[30] Harvey G. Agnew, ***Canadian hospitals 1920-1970, a dramatic half century***, (Toronto: University of Toronto Press, 1974).

In recent years, American historians have generated a body of literature about the development of the modern hospital in the United States. Although the evolution of Canadian hospitals was not identical to the evolution of American institutions, many of the developments which took place during the late 1800's and early 1900's were similar on both sides of the forty-ninth parallel. Ideas and innovations ignored borders and the fact that Canadian health care professionals often sought further education in the United States certainly enhanced the flow of ideas. The professionalization movement which took place within nursing exemplifies the strong linkages which existed between the two countries. Indeed, the foundation of the American Society of Superintendents of Training Schools for Nurses of the United States and Canada, and of the Nurses' Associated Alumnae of the United States and Canada in the late 1800's reflected the common interests and challenges that confronted the fledging profession in both countries. The example provided by nurses bi-national types of associations was soon followed by those of other hospital workers such as administrators and superintendents. In fact, Canadians and Americans had much in common and both groups were challenged by transformations affecting the entire western world. Industrialization, bureaucratization, waves of immigration, and the urge to develop each country's western frontier occurred almost simultaneously and often followed similar patterns. Thus, it may be suggested that historical work about the American experience can be considered relevant to the study of Canadian institutions. It is important to note that the four general hospitals of Edmonton were all founded during the period of time studied by American researchers.

Vogel, Rosner and Rosenberg have proposed that the changes which took place during the later part of the nineteenth century and the first part of the twentieth century gave the hospital its salient contemporary characteristics.[31] Rosenberg further suggested that many of the features of the 20th century hospital had emerged by 1900.[32] Although these three authors highlighted different factors, their studies reflected a common thesis. They described the hospitals of the 1850's as institutions providing care to the poor, the homeless, and to those who had no one to take care of them at home. These institutions were rarely utilized by middle and upper classes of individuals and their curative functions were limited. In contrast, the same authors saw the 1920's hospitals as providers of a variety of curative services which could not be delivered in peoples' homes. Consequently, the modern hospitals were increasingly providing care to people of higher socio-economic backgrounds. The hospital "... had grown in size, had become more formal and bureaucratic, and increasingly unified authority, consistently reflecting medical needs and perceptions."[33]

---

[31] Vogel and Rosner focused on the social variables which influenced the development of the modern hospital in two metropolitan areas. Rosenberg also considered the importance of social variables. However, the emphasis of his work was on the role of physicians, and the geographical arena of his study was more national in nature. Morris

Collectively, these authors concluded that the discovery of the germ theory and the successful use of other therapeutic modalities such as anaesthesia significantly contributed to the refutation of ancient beliefs about disease causation, and growth of optimism about the possibility of human intervention to alter the disease process. As a consequence the dominant view that primarily linked disease with social status and low morals gradually faded away. The scientific discoveries and with resulting modification of belief systems had a profound impact on hospital workers and administrators who increasingly saw themselves as providers of treatment rather than as social reformers.

However, it is clearly demonstrated in the work of Rosner that external social political and economic factors contributed just as much if not more in changing the role

---

Vogel, ***The invention of the modern hospital, Boston 1870-1930***, (Chicago: University of Chicago Press, 1980); David Rosner, ***A once charitable enterprise. Hospitals and health care in Brooklyn and New York, 1885-1915***, (Cambridge: Cambridge University Press, 1982); Charles E. Rosenberg, ***The care of strangers. The rise of America's hospital system***, (New York: Basic Books Inc. Publishers, 1988).

[32] Rosenberg, Ibid.

[33] Rosenberg, Ibid., 6.

of the hospital.[34] In particular, it is seen that industrialization and immigration significantly transformed New York's landscape. Immigrants were attracted to factory neighbourhoods, which until then, had been predominantly occupied by middle and upper class population groups. The latter left these areas for less crowded and quieter surroundings. The in and out-migration had numerous direct effects on health care institutions. For example, wealthy patrons and physicians moved to new neighbourhoods and left local hospitals almost resourceless. By the mid 1890's, the rise of injuries and diseases related to industrialization, added to the increasing number of poor, homeless, and unemployed who had been the victims of economic depression. Importantly, these social problems further depleted the scarce hospital resources, and fearing bankruptcy, hospital trustees and superintendents began to seek new forms of income. Significantly, they proposed that introducing patient fees would contribute to solve the hospitals' financial difficulties. However, since the majority of patients were destitute they realized that this would not be a solution unless they could attract a wealthy clientele that would be able to pay for services and thus bear the brunt of hospital operating costs. Needless to say, a number of changes had to be implemented in order to convince the new target population that hospitals could be valuable to them. In particular, improving hospital living conditions and purchasing the technological tools requested by physicians who had traditionally provided services to these wealthier individuals were recognized as prerequisites to the success of the reform. It can be suggested that the administrators and trustees had opened a Pandora's box since the implementation of new services brought escalating costs and the emergence of new economic and power struggles.

Soon, hospitals became dichotomous institutions with sections for the poor and sections for the rich. Hospital superintendents and trustees were torn between their wish to continue to offer free services to the indigent (they had always considered it as their moral responsibility) and the necessity to satisfy the costly demands of physicians without whom they could no longer survive. The growing authority of physicians was an additional threat to managerial policies. Physicians assumed a presence of increasing importance on hospital boards and began to ascend to decision-making positions. Significantly, they used their new power to request the right to bill all patients, poor and wealthy alike. Consequently, physicians and hospital administrators engaged in lengthy battles that reflected a new order in which hospitals and medicine had become interdependent.

---

[34] Rosner, ***A once charitable enterprise***.

Vogel[35] demonstrated that hospital administrators were not passive agents and that they reacted to the new pressures occasioned by changes in society and the medical world. Recognizing the rising costs and the increasing complexity of hospital services, they founded the Association of Superintendents of the United States and of Canada in 1899. Importantly, the purposes of the new association were to exchange ideas on hospital management, and to foster the development of a managerial professional identity. However, although the association had some success, its members never reached the status that physicians held in society. For Vogel, the inability of the administrators to prove their social value explains why physicians "took over" the hospital for most of the twentieth century.[36] He also suggested that this inability was symptomatic of the social global phenomenon in which science was replacing morality as the central American value. Since physicians were increasingly seen as scientists a powerful aura began to be associated with their discipline while administrators, who could not claim to have a similar connection with science, were consequently left in the shadows.[37]

In general, the studies by Vogel, Rosner and Rosenberg are remarkable for their indepth use of archival material and for the context bound analysis which characterizes them. In addition, these authors expressed the view that physicians were not the only professionals or workers involved in the changes which modified the hospital at the turn of the century. However, it is remarkable that they all failed to analyze the role played by women in the creation of the modern hospital. The neglect of nursing is particularly salient. For example, it is worth noting that Vogel did not address the passage of control over hospital affairs from a majority of female superintendents to a majority of male superintendents. Likewise Rosner did not explore the societal impact of the emergence of the women's movement. Rosenberg's position is the most interesting from a nursing point of view. He wrote:

---

[35] Morris Vogel, "Managing medicine: creating a profession of hospital administration in the United States, 1895-1915," in ***The hospital in history***, ed. Roy Porter and Lindsay Granshaw, (New York: Routledge, 1989), 243-260.

[36] Vogel suggests that since the 1980's the increasing bureaucratic control of hospital medicine and the negative image of physicians are contributing to a diminution of the medical hegemony and to a rise of administrators' power. Ibid., 253.

[37] Vogel, ***The invention of the modern hospital***, 3; Similar conclusions were also reached by Rosenberg. Rosenberg, ***The care of strangers***, 144.

> Perhaps the most important single element in reshaping the day-to-day texture of hospital life was the professionalization of nursing. In 1800, as today, nurses were the most important single factor determining room and ward environment.[38]

However, only one page later, he stated that he had decided to highlight the role of the medical profession because "... their role was a dynamic one."[39] This is tantamount to saying that nurses were passive. Although Rosenberg's analysis of the contribution of medicine seems valid, it is believed that by paying lip service to nursing he failed to recognize that without the active participation of nurses, most changes could not have taken place.[40] Unfortunately, he left the reader with a number of observations that would have been worth analyzing. In particular, it seems that all cases in which women played a significant and innovative role were superficially examined. Among his comments on the Catholic hospital he wrote: "... the Catholic hospitals [...] provided a setting in which women could exert a greater degree of authority. They were insulated by their sex and vocation from the will of medical boards and by their orders from the unfettered control of diocesan administrators."[41] The fact that he did not further develop or explain the role of nursing sisters in Catholic hospitals lends support to the hypothesis that, consciously or not, he underplayed women's involvement in the shaping of the modern hospital.

---

[38] Rosenberg, ***The care of strangers***, 8.

[39] Ibid, 9.

[40] For example, it has been found that the growth and importance of the general hospital depended on creating a large labour force of competent nurses. In turn, this work force stimulated further developments. Christopher J. Maggs, ***The origins of general nursing***, (London: Croom Helms Editors, 1980; Susan Mokotoff Reverby, ***Ordered to care. The dilemma of American nursing, 1850-1945***, (Cambridge: Cambridge University Press, 1988).

As describe by Brodie nursing is invisible in most hospital and therapeutic modalities histories.[42] Significantly, she used Rosenberg's work as an example of that "invisibility" and proposed that nursing must be addressed to capture a more accurate picture of reality. For her, "the minimization of or absence in recognition of nursing's contribution coupled with an idealization of medicine's powers to advance medical care is so pervasive in historical analysis that it is the perceived view of medical history today."[43] In other words the history of medicine and the history of health sciences are commonly perceived as being such similar fields of enquiry that medicine is often given credit for all changes or innovations made in the provision of health care services.

One of the motivating factors behind this study was the wish to study the neglected majority. It was thus deemed important to examine the role of nurses and nursing sisters in a Canadian Roman Catholic hospital. It was and remains the contention of the writer that the professionalization of nursing, the increasing complexity of services provided by nurses and the evolution of nursing education cannot be dissociated from the evolution of the hospital. Nursing shaped the hospital and the hospital shaped nursing. This interdependency needed to be addressed in order to increase understanding of the history of nursing and of the hospital.

---

[41] Rosenberg, ***The care of strangers***, 423.

[42] Barbara Brodie, "The place of nursing in the development of medical care," ***Bulletin of the American Association for the History of Nursing***, (Spring 1991): 1-2.

[43] Ibid, 1.

CHAPTER 3

METHODS

This study was conducted using historical methods. The purpose of this chapter is to present and discuss the general principles underlying the research and guiding the research process. General considerations about the writing of history are presented and followed by a discussion about data sources, data analysis and synthesis. Finally, the limitations inherent in this study are identified and addressed.

The approach

As seen in the previous chapter, the literature revealed that most hospital histories have been enumerative, narrow in scope, and non-analytical. In addition, it was found that few authors have systematically studied the role of nursing in the development of the hospital. Those who have examined hospital histories unanimously suggest that the state of historical historiography will not improve unless more attention is given to the context in which institutions developed. This position is shared by the writer and is also congruent with her views on historical writing.

The writer believes that the purpose of history is to understand the past. It thus follows that the work of the historian cannot be limited to the identification of past events, but that it must also comprise the search for relationships between these events. It is indubitable that relationships can be proposed only if the context in which events occurred is examined and studied. The writer also subscribes to the position that the *a priori* selection of a theoretical framework is contrary to the historian's craft. If such a framework is selected it becomes almost impossible not to consciously or unconsciously select data that fits this framework. In other words, taking this approach could be likened to accepting an explanation of the past *a priori*. Discussing the consequences of such methodological approach the historian Marc Bloch wrote:

> The error was in considering this hypothesis as given at the outset. It needed to be proved. Then, once the proof - which we have no right to consider as infeasible out of prejudice - has been supplied, it still remains for us by digging deeper into the analysis to ask why, out of all imaginable psychological attitudes, these particular ones should have imposed themselves upon the group. For, as soon as we admit that a mental or emotional reaction is not self-explanatory, we

> are forced in turn, whenever such relation occurs, to make a real effort to discover the reasons behind it. In a word, in history, as elsewhere, the causes cannot be assumed. They are to be looked for...[44]

In a world that it is mesmerized by the scientific method of investigation some are tempted to evaluate historical work according to the tenets of this method, or at worst to propose that historical enquiry should be conducted using this method. As enunciated by Cramer, history does not rest in experimentation and theory: "History deals primarily with particular events and individuals, rather than the search for general laws. Prediction is impossible since circumstances are so varied they can never be duplicated."[45]

These considerations explain why the research questions selected for this project were broad and general in nature. Clearly stated, although the questions were used to guide the processes of data collection and analysis they were broad enough to permit the preservation of the open-mind attitude necessary to avoid the drawing of *a priori* conclusions. They permitted to consider all available data as potentially useful to the process of shedding light on the history of the hospital under consideration. To some degree this study represents a personal application of the well established historical methods developed by the *Ecole des Annales*. The writer subscribes to many of the tenets of this French school of thought, and it explains in particular why much attention was given to the social characteristics of the sisters who worked at the EGH and to attributes which shaped their *mentalité*.

Data Sources

Both primary and secondary sources were utilized in this project. Most of the primary data was found at the Grey Nuns Regional Centre Archives of Edmonton (ASGME), while secondary sources were primarily identified via the library network of the University of Alberta.[46] Information was also sought at the Alberta Provincial Archives, the Alberta Association of Registered Nurses Archives, the City of Edmonton Archives, and the University of Alberta Archives.[47]

---

[44] Marc Bloch, ***The historian's craft***, trans. by Peter Putnam, (Manchester: Manchester University Press, 1979), 197.

[45] Susan Cramer, "The nature of history: Meditations on Clio's craft," ***Nursing research***, 41, (January 1992): 6.

Primary data

As stated most of the primary data presented in this study was collected at the ASGME.[48] Importantly, the writer consulted all material pertaining to the EGH. The well organized systems of classification of the ASGME greatly facilitated the identification and retrieval of these documents. It must be noted that at least half of the information pertaining to the hospital was written in the French language. This did not pose a problem since French is the mother tongue of the researcher. Seven general categories of documents were found at these archives. They were: les Chroniques de l'Hôpital Général d'Edmonton [the EGH Chronicles]; les documents historiques [historical documents] which include letters, contracts and other papers; the school of nursing files; the chronology of the Edmonton General; annual reports and budgets of the EGH (1914-1936), the minutes of medical staff meetings and of the medical executive committee meetings (1933-1970), the minutes of the board of management meetings (1968-1970) and, procès verbal et visites canoniques [minutes and canonical visits]. In addition, the archives included a number of files pertaining to specific topics such as tuberculosis, equity clauses etc... Those were consulted as well as part of the sisters demographic files.[49] Finally, it must be stated that the ASGME included a collection of newspaper articles pertaining to their hospitals.[50]

---

[46] Interlibrary loans were utilised to obtain material not available at the University of Alberta. Some secondary data was also found in the private library of the Grey Nuns Order in Edmonton.

[47] The Medicine Hat Museum, Art Gallery and Archives, and the Galt Museum and Archives (Lethbridge) possessed relevant data about pioneering nursing in Alberta. This data is presented in Chapter 4 and was initially collected by the writer for a research project conducted by Dr. Janet Ross Kerr. Similarly, the data collected at the Grey Nuns Archives of Montreal was part of preliminary work which lead to the decision to study the history of the EGH.

[48] A complete listing of primary sources is provided in the bibliography of this dissertation. A very marginal amount of data was found at other archives. In particular, the writer was surprised by the fact that the Oblate Priests Archives (kept at the Alberta Provincial Archives) contained almost nothing about the EGH. Considering that these priests often collaborated and supported the work of the Grey Nuns the writer was hoping to find meaningful data concerning the EGH in their collection.

One of the most exacting tasks of this study was to find material directly related to the nursing service of the hospital. For example, as can be seen from the above listing, minutes of nursing committees were not preserved.[51] In fact, the school of nursing files were the only ones in which information about nursing was predominant. Thus, information about nursing had to be found in files predominantly related to other topics. It can be stated that although all files included some data about nursing, the amount of information and the precision of this information varied greatly. Overall, finding information about nursing was often difficult and required the use of detective skills. "Reading between the lines" was necessary and helped formulate a hypothesis that could be verified by using other sources of information. In fact it is believed that without a nursing background it would have been much more difficult to identify the traces left by the nursing profession. This would tend to confirm Connor's suggestion that health professionals "... have experience and insights that are indispensable to develop a balanced understanding of the origins, activities, and functioning of an institution as complex as the modern hospital."[52] Importantly, however, he recognized that these individuals can engage in historical research as long as they develop an awareness of the methods, issues and problems occupying historians' minds.

---

[49] Discussion about the nature of the documents contained in these categories is presented as documents are referred to in subsequent chapters.

[50] Newspapers consulted included: *The Edmonton Bulletin*, *The Strathcona Plain Dealer*, *The Edmonton Journal*, *L'Ouest Canadian* and *Le Franco*.

[51] It is suspected that for most of the period of time under investigation minutes about nursing activities were probably not recorded. This hypothesis is based on the fact that prior to the involvement of lay individuals in the hospital administrations, the institution governing body which was exclusively composed of sisters did not seem either to regularly record in writing the content of administrative meetings. Since at the same time the sisters were also in charge of most nursing activities, it appears logical that few minutes would have been taken. It may be suggested that the sisters believed that the preserving of official papers such as correspondence was probably sufficient, especially since important information was also recorded in the hospitals chronicles. Further, the family-like atmosphere which existed between the sisters probably made the taking of elaborate minutes unnecessary. In addition, the fact that the American College of Physicians and Surgeons which conducted hospital accreditation paid much more attention to medical than to nursing issues may also explain why minutes of physicians' meetings were recorded and preserved. It is important to state that based on her involvement in other projects, the writer believes that the non-catholic hospitals of Edmonton kept even fewer documents about nursing and that data related to the administration of these hospitals was almost silent on the topic.

Secondary data

Secondary data was primarily found in books, reports and articles in journals where a wide range of topics were examined. The most important of these were writings about the history of Alberta and of the city of Edmonton, of female religious orders, of Franco-Albertans, of health care and hospital insurance, of hospitals, of hospital and health care associations, and of nursing. Pertinent reports and documents published by governments and associations were also reviewed.[53] A number of professional publications were systematically reviewed including the *AARN Newsletter*, *The Canadian Nurse*, *Canadian Hospital*, and *Hospital Progress*. History periodicals were also consulted, the most important being: *Alberta Historical Review*, *Alberta History*, *Atlantis*, *Bulletin of the history of medicine*, *Canadian Bulletin of Medical History*, *Canadian Historical Review*, *Journal of Canadian Studies*, *The Canadian Catholic Review*, *Prairie Forum*, *Histoire sociale*, *Revue d'histoire de l'Amérique française*, and *Recherches sociographiques*. Generally, it was found that specialized books, theses and dissertations were much more useful than periodical articles. In fact, very little was found in journal articles, and this absence of relevant information might be seen as an indicator of the need for increased research in the topic of interest.

---

[52] Connor, "Hospital history in Canada and the United States," 103.

[53] For example, the *Report of the Royal Commission on Health Services* and the *Weir Report* were widely consulted.

Data Analysis

As stated earlier data was collected and analyzed according to historical methods of inquiry. Although the research questions guided data retrieval, it was found during the data collection period that the ASGME contained important information that had not be identified in preliminary searches. For example, it was possible to have access to demographic data concerning the sisters who had worked at the EGH. This information was useful to establish a portrait of the average sister of the hospital.[54]

External and internal criticism was carried out to assess the validity and reliability of the data. In particular, the researcher sought to find multiple primary data sources describing particular events. The identification of these sources was useful to determine the authenticity and credibility of each document. Once collected the documents were reviewed, classified and interpreted.[55] An important part of the interpretation consisted of establishing relationships between identified variables and issues. Secondary data was useful in this process since it often permitted one to have a better understanding of the context in which the events described in the primary data occurred. The final step taken in this study was to revisit the original research questions and to formulate answers based on the findings presented in the body of this dissertation.

Limitations

The fact that data could not be created is an inherent limitation of historical research. It is evident that in some cases that the non-availability of data posed some problems. In particular, the limited information about nursing care certainly made the task of describing and analysing the evolution of patient care services at the EGH and of nursing itself at that institution more difficult. In general, however, it is believed that even if data sets were not always complete, existing data was sufficiently detailed to answer the research questions.

---

[54] In addition, it will be seen that this demographic information was useful in respect of the type of link which existed between the EGH sisters and the Franco-Albertan community.

[55] Specific details about data treatment are presented within the chapters of this dissertation.

Having access to patient charts would have certainly added another dimension to this study. Such data would have facilitated understanding of the changes which occurred in health care services delivery between 1895 and 1970. Finally, it is acknowledged by the researcher that it was not possible to bring to light all aspects of the development of the EGH. This task was beyond the scope of this study and would have required a number of years of additional investigation.

CHAPTER 4

HISTORICAL BACKGROUND

The purpose of this chapter is to provide a general background about relevant aspects of the history of Alberta prior to the foundation of the EGH in 1895. The chapter is divided into three sections. The first one consists of a brief summary of aboriginal health practices prior to the establishment of western forms of health care delivery. The second section is devoted to the origins of nursing and hospital services in Alberta and includes an overview of the Grey Nuns' contribution followed by a similar discussion about the role of lay nurses. Finally, the third section encompasses historical overviews of the fur trade era, of the involvement of French Canadians and Métis in that activity, of the missionary work conducted in that period of time, of the Canadian expansionist movement, and of Edmonton as the hub of French Canadian settlers.

Aboriginal health care practices

It is essential to acknowledge here that being concerned about health and illness is a universal attribute of human societies. However, there are variations in the manner in which this concern is articulated, and in the way in which tools and systems are developed and utilized to address health issues. It may be stated that these variations are a function of the world view that is shared by the members of a given cultural group. It is clear that the aboriginal populations of Alberta had developed a health system that was congruent with their vision of the world. Unfortunately, the field of native history remains in its infancy and little is known about the past health practices of these first Albertans. The difficulty in exploring the roots of their practice is compounded by a number of factors including the degree to which they have been assimilated to the dominant culture and have themselves lost much of their ancestors' healing knowledge. It is also evident that the oral nature of their historical traditions has further complicated the preservation and communication of their history.

However, recent work sheds light on some of the health practices and related philosophical underpinnings of the Woodland Cree whose nation remains one of the most important ones amongst Alberta's native groups. The traditional vision of the Woodland

Cree is that "all things in the world are interrelated and mutually influence each other."[56] It is thus not surprising that in the Cree culture, religion and healing were closely linked and that the medicine man held a position of power and status in the community.[57] Healing practices included the use of medicinal plants, sweat lodges and other therapeutic modalities in which were incorporated religious ceremonials. It thus follows that the arrival of Christian missionaries was bound to have an impact on the health system of the aboriginal populations. In fact it has been suggested that by proposing a new religious belief system the missionaries directly affected a number of healing practices.[58] In addition, by coming west the white men brought new diseases which had never been encountered by traditional healers. Thus, it may be proposed that the understandable lack of knowledge of these healers about the new ailments contributed to a reduction of the faith people have had in traditional healing methods. Increasingly it may have pushed them to rely increasingly on the assistance of the Christian missionaries. However, in the occidental cultures, religion and medicine were more separate than in native cultures. Priests and ministers had limited health care knowledge. Nonetheless, the Roman Catholic priests were concerned about the health of the aboriginal populations and it is thus logical that they sought the assistance of nursing sisters. Some may be tempted to argue that the sisters further contributed to the erosion of aboriginal health practices. Although it is impossible to evaluate the extent to which this happened, it is clear that the sisters were motivated by the wish to assist those in pain and that they in fact offered a valuable service to the local populations. It is also likely that natives consulted them primarily for diseases that could not be cured by their healers. It is highly improbable that traditional healing practices which had been successful for centuries were abandoned overnight. If this had been so, it is doubtful that there would be any traditional healers in today's Alberta which is not the case.

---

[56] David E. Young, ***Cry of the eagle, Encounter with a Cree healer***, (Toronto: University of Toronto Press, 1989), 15. This author conducted an anthropological study of the healing practices of an Alberta Woodland Cree healer. At the time of arrival of the Grey Nuns, the Cree Indians occupied most of the northern and central portion of today's Alberta. Most French speaking Métis were of Cree ancestry.

[57] Ibid., 12; Virgile J. Vogel, ***American Indian medicine***, (Norman, Oklahoma: University of Oklahoma Press, 1970), 22.

[58] Young, Ibid., 12; Vogel, Ibid., 35.

The Origins of Nursing and Hospital Services in Alberta

The Grey Nuns

Three Grey Nuns arrived at *Lac Sainte-Anne* on September 24, 1859. Sister Emery (Marie-Zoé Leblanc), 33 years old, was in charge, and Sisters Lamy (Adèle Lamy) and Alphonse (Marie Jacques) who were 24 and 23 years of age were her companions. Sister Collette, a member of the Grey Nuns' Order described Sister Emery as a humble, discreet and meticulous worker, Sister Lamy as a distinguished and reserved individual, and Sister Alphonse as a happy and enthusiastic person.[59] It is also known that Sister Alphonse and Sister Lamy were childhood friends and came from the same area of Quebec as Father Lacombe. They had studied at *Yamachiche* (village located on the North shore of the St. Lawrence River, nearby *Trois-Rivières*), had entered the Grey Nuns novitiate together and taken the veil on the same day. Sister Emery was also from a rural area (*St-Jacques de l'Achigan*) and according to Sister Alphonse she particularly enjoyed horse back riding.[60] After having spent nine months of preparation in Manitoba, they left St-Boniface on August 4, 1859. Sister Alphonse kept a diary of their adventure through the prairies. The detailed and touching account of their voyage has been preserved at Mother House Archives located in Montreal.[61] Although Sister Alphonse mentioned the hardships of the voyage, her narration was positive and displayed a taste for adventure and discoveries. Her writings conveyed an unshakable faith in God, and a profound conviction that her mission in life was to assist those in need. As expressed by Sister Bonin, in 1983, the uniqueness of the Grey Nuns resides in the call "... to show, to witness, the mercy, the compassion, the love that the Heavenly Father has toward all, especially the needy."[62]

---

[59] Archives des Soeurs Grises de Montréal, Edmonton (ASGME). Lac Sainte-Anne historique. Préliminaires de la fondation du Lac Sainte-Anne. Saint-Albert historique 1859. Document 6. Testimony of Sister Collette, n.d.

[60] Archives des Soeurs Grises de Montréal, Montréal (ASGM), Lettres de St-Albert 1858-1877, "Journal de Voyage" de Soeur Alphonse, Copie conforme de l'ancien cahier numéro 1, 10.

[61] ASGM, Lettres de St-Albert 1858-1877, "Journal de Voyage de Soeur Alphonse." An identical copy of this document was also found at the ASGME, Lac Sainte-Anne historique, Doc. 23.

The new life in the little mission of thirty people immediately provided the three Sisters with challenges and much work to be done. Beside providing nursing care and teaching the local children the sisters contributed to the farming activities and were in charge of most of the domestic work, including cooking and laundry for themselves and the Oblate Fathers. The Fathers and the Grey Nuns had to produce their own means of subsistence and the sharing of their respective abilities was probably essential to their survival. Generally, tasks were assigned according to traditional sex roles. However, this was not always the case, because more often than not, the Fathers had to travel to accomplish their missionary work, thus leaving the Sisters alone for days and even weeks. Letters of Sisters Emery and Lamy are quite revealing. In 1860, Sister Emery wrote: "Ici, il faut être de tous les métiers. Il y a quelques jours, j'ai montré à un pauvre homme à vanner de l'orge. C'était un peu extraordinaire de voir une Soeur Grise à un tel ouvrage; le Père Lacombe était absent."[63] In 1862, Sister Lamy gave similar information to her Montreal readers: "Je crois, Chère Mère, qu'il est inutile de vous dire que tous nos moments sont bien employés. Nous sommes seules pour toutes notre besogne; depuis l'étable jusqu'à la sacristie. Notre Chère Soeur Supérieure prend à elle seule le soin de la cuisine, et ma soeur Alphonse et moi, outre nos offices, nous avons

---

[62] ASGME, EGH, Anglais 1837, Doc. 38, Sister Marie Bonin, Address delivered at the 'Appreciation Diner' at the Grey Nuns Regional Centre, Edmonton, 4 May 1983.

[63] Quote translation: "Here one has to be a jack of all trades, a few days ago, I taught a poor man how to winnow barley; it was rather extraordinary to see a Grey Nun doing this; Father Lacombe was away." ASGM, Lettres de St-Albert 1858-1877, Letter of Sister Emery, Lac Sainte-Anne to Mother Deschamps of Montreal, 13 April 1860, 35.

entrepris les jardinages."[64] Life at *Lac Sainte-Anne* was difficult and the land did not provide sufficient crops. Agricultural issues were probably the chief basis for the missionaries' decision to relocate their mission at St. Albert in 1863.

Of particular interest is the nursing work accomplished by the Sisters during those pioneering years. Although *Lac Sainte-Anne*'s mission did not have a hospital and neither did the St. Albert's mission until 1881, the sisters were involved in health care as soon as they arrived in the Northwest Territories. It must be recalled that medical services were not available, and that all health care services were provided by the nursing sisters. During the first years of the mission, Sister Emery was assigned the nursing duties. She had what we would label today an expanded nursing role. She was the nurse, physician, pharmacist and even dentist of the area. In 1859, Sister Emery recognized that she did not always know how to proceed and she attributed many of her patients' recovery to the faith they had in her abilities.[65] Data indicates that home visits were common and a favoured way to reach those in need. For example, Sister Emery recorded that forty-eight home visits were done and 100 patients were treated between August and December 1864.[66] An anonymous description of the mission of St. Albert also gives interesting information about the Sisters' work: "L'Asile d'Youville est aussi ouvert aux malades, et comme il n'y a pas de Docteur dans le pays, les soeurs sont dans la nécessité de les remplacer. Elles distribuent des remèdes pour les malades de St-Albert et des environs, et vont visiter et soigner autant qu'elles le peuvent à domicile ceux qui sont à leur portée."[67]

---

[64] Quote translation: "I believe, Dear Mother, that it is not necessary to tell you that all our time is well used. We are alone for all the work; from the stable to the sacristy. Our dear Sister Superior takes care of all kitchen work, and Sister Alphonse and I, beside our regular duties, have undertaken the gardening." ASGM, Lettres de St-Albert, 1858-1877, Letter of Sister Lamy, Lac Sainte-Anne to Mother Deschamps of Montreal, 8 May 1862, 85.

[65] ASGM, Lettres de St-Albert 1858-1877, Letter of Sister Emery to Mother Deschamps, 4 December 1859.

[66] ASGM, Lettres de St-Albert 1858-1877, Letter of Sister Emery to Mother Slocombe, 11 December 1864, 160.

In 1870, the population of St. Albert had reached 700 people. According to Sister Emery the influx of immigrants made necessary the establishment of a designated room to receive patients in the convent.[68] Thus, a patient ward was opened in 1870.[69] The creation of this service could not have been more timely because a few months later a smallpox epidemic reached the region and the new ward was rapidly filled by patients needing around the clock nursing services. The magnitude of the epidemic can be seen considering that it has been estimated that 600 residents of St. Albert contracted the disease and that 320 of them did not survive.[70] In a letter written in January 1871, Sister Emery described the nursing activities during the second half of 1870. She reported that 36 families had been visited for a total of 692 home visits. She further indicated that 22 patients received wound care, that 218 children and 133 adults were vaccinated and that the Sisters distributed 392 meals.[71] It would have been interesting if Sister Emery had indicated the number and type of medications that were administered. However, based on a letter she wrote in November 1870, it may be suggested that few would have been given in November and December since the supplies were probably almost depleted by then because half of the last shipment had been destroyed by water during the long journey between Montreal and St. Albert.[72] Yet, considering the state of medical and pharmaceutical knowledge at the time, it is reasonable to believe that the enumeration of the services provided by the sisters corresponds to what would have been achieved elsewhere, even under better conditions. What is remarkable is that the sisters accomplished that much with so little household commodities and material supplies.

---

[67] Quote translation: "The Youville Shelter is also open to sick people and as there are no doctors in the country, the sisters have, of necessity, to replace them. They give out medicines to the sick of St. Albert and vicinity and visit and care for as many as they can in their homes, if it is within a reasonable distance." ASGM, Lettres de St-Albert 1858-1877, Quelques notes sur l'établissement de St-Albert. Par un ami de la mission de St-Albert. [Some notes about the St. Albert's mission. By a friend of the mission.], 93.

[68] ASGM, Lettres de St-Albert 1858-1877, Letter of Sister Emery to Mother Slocombe, n.d., received in Montreal 16 April 1870, 203-221.

[69] ASGME, Chroniques de l'asile d'Youville de St-Albert, Volume I - 1859 to December 1915, 11.

[70] James MacGregor, ***A history of Alberta***, (Edmonton: Hurtig Publishers, 1972), 92.

[71] ASGM, Lettres de St-Albert 1858 1877, Sister Emery to Mother Slocombe, 6 January 1871, 247-253.

Manual work was definitely more extensive than in the convents of Eastern Canada, and evidence shows that technology was less available. For example, for many years the sisters did all laundry at the river side which was certainly no longer the case in Montreal.[73] Sister Charlebois reported that during the 1871 smallpox epidemic the higher than usual combination of home care and inpatient care created such a workload that the Bishop Grandin designated fathers and brothers for night duty.[74] This assistance must have been welcome by the sisters. During the epidemic the sisters also closed the mission school in order to limit the propagation of the disease.[75] This measure also allowed them to alter the functions of the teacher for the duration of the epidemic.

It seems that all along the Grey Nuns' nursing services were appreciated by the population. Records indicate that dignitaries such as the Hudson Bay Company agent and other individuals of Fort Edmonton provided occasional financial assistance. Parishioners of St. Albert also expressed their gratitude by their generosity. The chronicles of the missions indicate that the establishment of the first hospital at St. Albert in 1881 was facilitated by their generosity. It is reported that on Christmas Day 1878, the parishioners gave $221.85 towards the construction of a hospital wing.[76]

---

[72] It is important to note that Sister Emery indicated in her letter that medications frequently arrived in poor condition. ASGM, Lettres de St-Albert 1858-1877. Sister Emery to Mother Slocombe, 27 November 1870, 239-245.

[73] It was only in 1890 that a laundry room was added to the St. Albert Mission. ASGME, Chroniques de l'asile d'Youville de St-Albert, Volume I - 1859 to December 1915, 59.

[74] ASGM, Lettres de St-Albert 1858-1877, Letter of Sister Charlebois to Mother Slocombe, 20 December 1871.

[75] Ibid.

The Grey Nuns missionary work was not limited to *Lac Sainte-Anne* and St. Albert. After 1862, they expanded their services to other parts of the Northwest Territories. In 1898, 38 sisters resided in Alberta.[77] They were found in St. Albert (Asile d'Youville), in Calgary (Holy Cross Hospital), in Edmonton (Edmonton General Hospital), at *Lac LaBiche* (Hospice St-Joseph), at Standoff (Hôpital Notre-Dame des Sept Douleurs) and in Dunbow (Ecole industrielle St-Joseph). All missions offered some health care services; however, the Holy Cross Hospital and the Edmonton General Hospital really had the features of modern institutions. They were imposing buildings constructed to accommodate the medical practice of the time.[78]

Lay nurses

Prior to the establishment of the EGH in 1895, a small number of hospitals were operating in Southern Alberta, and lay nurses had arrived in the province. The majority of the first lay hospitals had been created to offer health care services to rail road and coal mine workers, and to police officers. Contrary to the Grey Nuns' mission "hospitals" these institutions had been established for a special segment of the population. Their original purpose was primarily to serve employees as opposed to aboriginal people and settlers. Another important distinction was that from inception physicians had powerful roles in these institutions. In particular, they often operated and administered these hospitals. During the same era, Grey Nuns' institutions were still often located in areas where physicians were rare and even if present they were not given major administrative responsibilities. Thus, the sisters' hospitals were always operated and administered by nursing sisters.

---

[76] ASGME, Chroniques de l'asile d'Youville de St-Albert, Volume I - 1859 to December 1915, 27.

[77] Missions had also spread to the current Saskatchewan and Northwest Territories. ASGME, Circulaires mensuelles adressées aux diverses missions de l'Institut, Volume 6, 1895-1898, Circulaires de janvier et février 1898. Statistiques du premier janvier 1898, 551-552.

[78] Both hospitals had an operating room and a laboratory.

The involvement of physicians from the outset in lay hospitals is more than likely related to the time of establishment of these institutions. When the Grey Nuns began to offer services in Alberta, the province did not have any physicians. This was no longer the case when a hospital system began to emerge in Southern Alberta. However, it is also possible that company hospitals might have been more attractive to physicians than religious missions, because the profit-making mind set of these hospitals would have assured them of a higher income, and because their lay administrative structure would have also given them more decision-making power. Finally, the fact that southern Alberta already had railways while the north remained devoid of modern transportation systems might have been a drawing force which contributed to the earlier settlement of physicians in that portion of the province.

As the population of southern Alberta increased, the company hospitals began to treat immigrants and settlers. This was the case at the Fort MacLeod hospital which had been established in 1874 by the Northwest Mounted Police. Similar developments occurred at the Medicine Hat General Hospital (incorporated in 1888), which had grown out of "...the makeshift hospital that came with the railroad in 1883".[79] The Galt Hospital established at Lethbridge in 1892 had a similar evolution. Originally, it was a mining hospital operated and maintained by the Alberta Coal and Railway Company. Importantly, the first lay nurses worked at these institutions and some of them contributed to the rise of the "Nightingale type of nursing" in Alberta. For example, it was the case for Miss Birtles who after receiving her nursing education at the Winnipeg General School of Nursing came to Medicine Hat to assist Miss Reynolds who had been educated under Nightingale graduates in Great Britain.[80] Other nurses such as Miss Chapman had been educated at the Montreal General Hospital. Thus, it is not surprising that the first school of nursing of Alberta was created in the southern portion of the province, at the Medicine Hat General Hospital in 1894. Although Miss Reynolds (by then Mrs Calder) was not the matron at the time, it is believed that her leadership was instrumental in the development of this school.

---

[79] Tony Cashman, ***Heritage of service, the history of nursing in Alberta***, (Edmonton: Alberta Association of Registered Nurses, 1966), 23.

[80] Ibid.

Little has been preserved about the work of the first Alberta lay nurses. However, it is certain that they experienced the hardships of settling in a frontier region. A letter from Mary Ellen Birtles (Medicine Hat General Hospital) and information provided by Nelle Chapman Higinbotham (Galt Hospital) give unique accounts of what life must have been like for many pioneer nurses. In May 1939, Miss Birtles wrote the following about her experience at Medicine Hat when she and Miss Reynolds were the only two nurses of the hospital:

> It was in February 1890 that I first went to Medicine Hat [...]. There was no domestic help so of course Miss Reynolds and I managed the work between us, she prepared the meals and looked after the downstairs work. I attend[ed] to the furnace and did the upstairs work, sweeping, dusting, etc... besides attending patients. When any surgical work was to be done we had to arrange the work accordingly. Miss Reynolds gave the anaesthetic and I looked after the instruments and waited on the doctors [...]. It was a different matter to obtain domestic help, either maid, cook or orderly and still more difficult to keep them, conditions were so different in a hospital to what they were accustomed to. [...] We were on duty every waking hour, day or night. In the case of a sick patient or new surgical case I would take night duty. We just simply divided the work between us.[81]

The words of Miss Reynolds resemble those of the Grey Nuns. Like the sisters, the lay nurses had to accomplish most of the domestic tasks, were 'on call' twenty-four hours a day and could not count on hired help.[82] Her mention of Miss Reynolds' role as on-site anaesthetist corresponds to the custom of the time. Indeed, nurses pioneered the administration of anaesthesia. This has been recognized by nursing historians. However, it is rarely acknowledged by medical historians and unknown by most people.

---

[81] Medicine Hat Museum and Art Gallery and Archives, Medicine Hat, Access #: M86.28.28F1. Letter of Mary Ellen Birtles written in 1939. The document is hand written and there are no indications of the recipient of this correspondence. The details of the content tend to suggest that the document must conform to reality.

[82] In a letter to Mother Deschamps written on May 8, 1862, Sister Lamy indicates that reliable assistance was difficult to find. ASGM, Lettres de St-Albert 1858-1877, 85.

Mrs. Higinbotham, a graduate of the Montreal General Hospital School of Nursing, gave a similar account of her nursing experience at the Galt Hospital. In her letter, she indicated the presence of a practical nurse in Lethbridge. In those days, it was not uncommon for unprepared women to act as health care providers, since the number of professionally trained individuals was very limited. This was particularly true for perinatal care which was usually the responsibility of a local lay midwife. Mrs Higinbotham gave this description of her nursing experience at Lethbridge:

> For the first year that I was in the Hospital, our patients were mostly men, accidents in the mines, and stabbing affrays at Slav and Hungarian weddings filling up the wards. The miners made very good patients, and except for coal dust, were very clean; we never found 'live-stock' on them, such as we found on dock workers at the MGH [Montreal General Hospital]. The work in the hospital varied a good deal. For some weeks all beds would be occupied, with additional camp beds placed wherever possible. Time off duty was almost impossible except when we were able to get outside help, which we could occasionally, there being a very capable practical nurse in Lethbridge, a Miss Barnes, whom we used to get in for extra night duty, but as she was always nearly dated up for maternity cases, she was only occasionally available.[83]

In the later parts of the nineteenth century, lay nurses and practical nurses certainly played an important role in the provision of health care in Southern Alberta where Catholic nursing orders were not as present. During the twentieth century the number of lay nurses steadily increased and they eventually out numbered nursing sisters everywhere in the province. The creation of schools of nursing in all major hospitals contributed to the growth of the nursing workforce and to a greater availability of nursing services throughout Alberta.

---

[83] Galt Museum and Archives, Newspapers collection, ***Lethbridge Herald***, "Extension to the Galt Hospital." 20 June 1931, 3.

Alberta prior to gaining provincial status

The development of nursing and hospital services in Alberta cannot be fully understood without examining how the province was explored and settled by newcomers. The arrival of the Grey Nuns and later of the first lay nurses was preceded by a series of events that made logical their coming to the frontier.

The fur trade era

Before the second half of the nineteenth century few people of European origins had set foot in the Northwest Territories. MacGregor described the country in these terms: "In 1858 the provinces [Alberta and Saskatchewan] which were merely a part of Rupert's land, which in turn was only that part of British North America belonging to the Hudson's Bay Company, were an empty land still controlled by a few fur traders".[84] Fur trade was indeed the most important commercial activity of the area. This industry was then well established in Canada and it was as old as the arrival of the first Frenchmen on the Atlantic coast in the sixteenth century. From the outset, furs and especially beaver pelts became the most important export of New France. The greater quality of this natural resource in northern areas was certainly one of the reasons which contributed to the exploration of the Canadian Shield and of the regions west of the Great Lakes. Water routes were the favoured mean of locomotion and it was by using the hydrographic system that LaVérendry reached the Rocky Mountains in 1731. Even if other motives such as the search for the Northwest Passage, also pushed LaVérendry and the following generations of explorers to go further west, it remains true that the discovery of new fur trading grounds was a welcome bonus.

The conquest of New France by Britain was by no means the end of fur trading activities. The interest in the product remained and the ferocious competition between the British owned Hudson Bay Company and the Canadian (Montreal based) owned North West Company demonstrates the economic importance of the trade. Although some have argued that the competing companies wanted to monopolize the west and that the fur trade industry was not the only factor behind their interest in the area, it is clear that the fur trade and the activities surrounding it were important for the development of the country and of the west. The men and women who devoted their lives to the enterprise certainly contributed to the birth of contemporary Alberta. Generations of Canadians have come to equate the fur trade with the founding of their nation. The mythology created around the *coureur des bois* and the *voyageurs* is a vivid element of the Canadian collective memory. The choice of the beaver as a national symbol is but one of the numerous indicators of the importance attributed to the activity. In reality, the fur trade did reshape the country by bringing *voyageurs* and explorers who were followed by missionaries and finally by settlers.

---

[84] MacGregor, ***A history of Alberta***, 73.

French Canadians, Métis, and the fur trade in Alberta

The Hudson Bay Company (HBC) and the North West Company (NWC) were administered and functioned in similar ways. However, their hiring policies were quite different. Understandably, the Montreal based NWC hired more French Canadians than the HBC which favoured British subjects. According to Morice[85] and Morton,[86] no one could equal French Canadian trading abilities. Like many others, both authors have probably exaggerated the superiority of the *voyageurs*. However, evidence indicates that the longer experience of French Canadians in the business and their greater knowledge of aboriginal cultures placed them in an advantageous position. Marriages between French Canadian traders and native women were also common which contributed to the success of trading activities. The fur trade was most successful when a number of formalities were observed, and having a native wife facilitated encounters.[87]

---

[85] A.G. Morice, ***Histoire de l'église catholique dans l'ouest canadien (1659-1905)***, Vol. 1, (Montreal: Granger, 1912), 72-73.

[86] Arthur S. Morton, ***A history of the Canadian West to 1870-1871***, 2d, ed., (Toronto: University of Toronto Press, 1973), 327.

[87] Olive P. Dickason, "From 'One Nation' in the Northwest to 'New Nation' in the Northwest: A look a the emergence of the Métis." In ***The new people: Being and becoming Métis in North America***, ed. Jacqueline Peterson and Jennifer S.H. Brown, (Winnipeg: University of Manitoba Press, 1985), 24; Sylvia Van Kirk, ***"Many tender***

Intermarriages were favoured among the traders since kinship was crucial in Amerindian commercial activities and trading alliances. In addition to vital family connections, a native wife brought special skills which were useful if not essential to trading activities. Many of the Métis who emerged from these unions followed in the footsteps of their fathers and were employed by the fur trade companies. They played an important role in the trade especially after the merging of the HBC and NWC in 1821. At the time, most of the fur trade industry was located in the hydrographic basin of the North Saskatchewan River, which had transformed Fort Edmonton into the hub of fur trading activities. French speaking Métis were always numerous at the Fort. In fact, French was the commercial language until the mid nineteenth century, and it was the most commonly spoken language in the trading posts of the region.[88]

Missionaries and the fur trade

As was the case during the seventeenth century, French speaking fur traders were followed by French speaking missionaries who hoped to convert native populations and also ensure that French Canadian traders would continue to adhere to the rules of their religion. The same tradition brought the Grey Nuns to provide health care services and education. The HBC authorities had mixed feelings about the missionary activities of the Roman Catholic priests and nuns. Carrière has studied the relationship between the priests and the HBC. Although he found that in general that the HBC and the Catholic Church had positive relationships, it is also apparent that animosity existed. In particular, his analysis of 1850's correspondence between George Simpson (Governor of Rupert's land) and James Anderson of the HBC revealed that it was felt by the HBC that the Roman Catholic influence was greater than desirable, but that keeping on good terms

---

ties." Women in the fur-trade society, 1670-1870, (Winnipeg: Watson and Dwyer Publishing Limited, 1980; reprint, Winnipeg, Watson and Dwyer Publishing Limited, 1986), 4.

[88] Edward S. Hart, ***Ambitions et réalités, la commmunauté francophone d'Edmonton***, translated by Guy Lacombe and Gratien Allaire, (Edmonton: University of Alberta Press, 1981), 7.

with missionaries was necessary because of the leverage they had on Métis and Natives.[89] Similarly, Archer found that the HBC wished to control mission work regardless of the denomination. However, "for philanthropic as well as for business reasons it was deemed desirable to encourage some religious activities. It was expected that Christians missionaries would raise the moral level of society making the population more honest and more tractable".[90]

The fur trade companies always feared that the arrival of missionaries would directly interfere with their commerce. According to MacGregor, John Rowand (Chief Factor of Fort Edmonton) expressed apprehension when Father Jean-Baptiste Thibault came to the Fort in 1842.[91] The fear of the HBC authorities was legitimate considering that missionaries wished to transform Métis and Native populations into sedentary and agrarian ones. Pressures to achieve a more sedentary life had always meant that farming supplanted hunting as the number one activity and that domesticated animals gradually replaced wildlife, thus leading in the long term to the disappearance of the fur trade industry. During the mid nineteenth century, HBC officials were expressing the view that the area was not suited for agriculture. George Simpson was among those who professed that the parklands were not "well adapted for settlement."[92] Although evidence of the time tended to support this position, the true motive of the HBC in defending this view might have been related to commercial interests. For MacInnis the company "... had persistently misrepresented the character of the country, in order to preserve it for the fur trade."[93] The Territories ownership battle which led to the revocation of the HBC charter lends some support to this hypothesis.

---

[89] Gaston Carrière, "L'honorable Compagnie de la Baie d'Hudson et les missions dans l'ouest canadien," In ***The Canadian Catholic Historical Association, Report of 1965***, (Ottawa: The Canadian Catholic Historical Association, 1965), 63-80.

[90] John H. Archer, "The Anglican Church and the Indians in the Northwest," ***Journal of the Canadian Church Historical Society***, 28 (April 1986): 19.

[91] Jean Baptiste Thibault, an Oblate missionary, was the first visiting priest of Fort Edmonton. He also founded the mission of *Lac Sainte-Anne* in 1843; MacGregor, ***A history of Alberta***, 63.

[92] Ibid., 73.

The Canadian expansionist movement

The ownership of the Northwest was actively contested between 1856 and 1871. Many factors contributed to the renewed interest of Canada for this part of the continent. In an in-depth study of the expansionist movement, Owram suggested that three factors pushed Canada to claim the area. First, the invention of the railway led Ontario entrepreneurs to dream of a western market where they would sell their goods. Second, the opening of a railway reaching the west coast would also facilitate commerce with Asia and strengthen the British Empire, and third, the geography of Ontario limiting the development of new farming areas made necessary a westward expansion.[94] Similarly, others have suggested that Canada needed a "backyard" where manufactured goods would be exchanged for agricultural products,[95] and that international pressures were also an important factor.[96] "The ownership of the Northwest was soon to become a race between Confederation and the clutching fingers of the United States".[97]

In 1857, the British and Canadian governments each commissioned research expeditions. The Palliser expedition (sponsored by the British government) and the Hind expedition (sponsored by the Canadian government) were created to provide objective data on the resources of the Northwest. Both surveyors found agricultural and mining potential in the territories. In addition, contrary to previous expeditions which had focused on northern areas (ideal fur trade territories) they closely examined the southern regions of the area and concluded that they were particularly suited for settlement. The results of these expeditions combined with the factors previously enumerated led to the loss of ownership of the area by the HBC in 1870 which further led Canada to claim supremacy over the Northwest Territories.

---

[93] C. M. MacInnis, ***In the shadow of the Rockies***, (London: Rivingtons, 1930), 252.

[94] Doug Owram, ***Promise of Eden. The Canadian expansionist movement and the idea of the west 1856-1900***, (Toronto: University of Toronto Press, 1980), 42-44.

[95] Arthur I. Silver, ***The French Canadian idea of Confederation, 1864-1900***, (Toronto: University of Toronto Press, 1982), 71; Gerald Friesen, ***The Canadian Prairies - A history***, (Toronto: University Of Toronto Press, 1984) 162.

[96] Gerald Friesen, ***The Canadian Prairies - A history***, 162; MacGregor, ***A history of Alberta***, 82.

[97] MacGregor, Ibid.

The transfer of ownership brought difficulties that could have been expected but which were overlooked by enthusiastic easterners. "It was one thing to achieve sovereignty over this vast empire, quite another to consolidate a national economy and to establish Canadian institutions throughout."[98] The most dramatic incidents occurred in Manitoba with the first Métis upsurge lead by Louis Riel. The aftermath of the conflict left the Métis landless and persecuted. In fact "the intolerance of Ontario immigrants in the West and the bigotry against the Métis revealed why Riel had felt it necessary to gain some guarantees for his people."[99] The conflict also resulted in language disputes and population cleavage based on racial and religious differences that went beyond the traditional French and English dualism. In the following decades, "good immigrants" were defined as white, British, and Protestant, and those who did not belong to that group were treated with suspicion.[100] The writings of MacInnis reflect the prominent mentality about potential settlers: "Western Canada could easily do without thousands of the offscourings of Eastern European peasantry, with their slave mentality and their traditions of oppression, if their places could be filled by young Englishmen of education and courage, such as the majority of the remittance men were."[101]

To fulfil the promise of a Canada where the institutions of the east would be reproduced in the west, the Macdonald government deemed it essential to link the country by a transcontinental railway. The adherence of British Columbia to the Confederation was made possible by the promise that trains would reach the Pacific coast. Friesen summarized the factors which gave to the transcontinental railway its national importance. The construction of a transcontinental line could demonstrate the ability of Canada to stand at the forefront of technological developments. Such line was seen as an asset that could contribute to the development of a national economy. Last but not least, it could solidify the nation's claim to the Northwest thus putting an halt to American expansionist ambitions. "Thus, national pride, economic interest, and territorial integrity all were bound up with the drive for a national rail link."[102]

---

[98] Friesen, *The Canadian Prairies - A history*, 163.

[99] Owram, *Promise of Eden*, 99.

[100] Ibid, 137.

[101] MacInnis, *In the shadow of the Rockies*, 329.

The railway played a concrete role in the development of Alberta. Areas where trains first arrived developed at a faster rate. After many debates surrounding the choice of a route for the transcontinental Canadian Pacific Railway it was decided that the line would be built in the southern part of the country. The completion of the line through Alberta in 1883 set the stage for settlement and economic growth of Southern Alberta.[103] Until then rivers had been the main means of transportation, thus increasing the chances of development of areas adjacent to major hydrographic systems. For much of the nineteenth century Edmonton had benefited from its location on the North Saskatchewan River. During the last decades of the same century the advantage shifted to Calgary because it had a railroad on its doorstep which was by then better than a water route. The railway brought many changes to Alberta and it significantly contributed to the passage from a fur based economy to a wheat based economy.

Macdonald's scheme also included the idea that law and order had to accompany the development of the West. It was for this purpose that the Prime Minister created the North-West Mounted Police who reached the Prairies in 1874. The police were to protect citizens as well as the country's sovereignty. Similarly to the beaver and the fur trade, the Mounted Police became a symbol of Canada. "The importance of the force in Canadian history can be demonstrated by reference to the 150 tales of adventure and romance that have placed the Mounties in a prominent role."[104] These stories came into being probably because of the unusual roles that were played by police agents. Among the rather atypical functions for a police force the Mounties took census, delivered mail, collected custom duties, served as justices of the peace, recorded weather and agricultural information, and provided medical services.

---

[102] Friesen, ***The Canadian Prairies - A history***, 172.

[103] Palmer and Palmer, ***Alberta a new history***, 50.

The federal government had hoped that the services provided by the police force coupled with the availability of the railway would be powerful immigration incentives. However, the number of immigrants remained under the expected level. According to Friesen, only 1.5 million of immigrants entered Canada between 1867 and 1899.[105] In contrast, the population of the United States was increased by 5.5 million during the same time period. Nevertheless, the population of the prairies steadily increased, as well as social institutions which started to challenge the power held by territorial and federal authorities. The Northwest Rebellion of the 1880's followed by a plea for provincial status were symptoms of the unrest and low satisfaction of the inhabitants who wished to take more direct control over their destiny. It can be suggested that the gradual development of governmental structures, of institutions such as schools and hospitals, and the completion of local railway connections in the 1890's all set the stage for the greater wave of immigration that occurred after 1897. Friesen presented the forces which contributed to the rise of immigration. First, it has been proposed that Canadian government recruiting campaigns were more aggressive and effective during that period of time. Second, changing international circumstances favoured Canada. For example, the increasing market value of wheat made wages seem higher in Canada than in Europe. Third, new farming technologies made agriculture more appealing; in fact, a agricultural boom took place. This, in turn, stimulated other industries such as coal mining, lumber and railway constructions which lead to the arrival of even more newcomers.[106] In addition, to these factors, it has been proposed that the "closing" of the American frontier in the 1890's played a significant role in the renewed interest for Canada.[107]

---

[104] Friesen, ***The Canadian Prairies - A history***, 163.

[105] Ibid., 185.

For Jackel the expansion of the newspaper press, which took place on both sides of the Atlantic, was more than a negligible factor in the rise of immigration. The Canadian government turned to newspapers for publicity. Significantly, part of the campaign was directed at potential female immigrants, and it seems that it was fairly successful at attracting women from the British Isles.[108] The increasing presence of women on the prairies was a factor that contributed to the development of a more structured society in which education and health care services were provided. In particular, women of British origins were conscious of the interdependence of education, economic independence and social mobility.[109] Health and welfare were also among their preoccupations. Archival materials relating to hospitals would support this position. The number of ladies aid societies and of IODE (Imperial Order Daughters of the Empire) chapters which emerged in hospitals at the turn of the century is a strong indicator of women's involvement in the social aspects of life. It must be recognized that the provision of organized health care services was limited to urban areas. In rural areas the situation was grim and women had to rely on their own resources and knowledge. The isolation of rural areas as well as the lack of government involvement contributed to the unavailability of services. In particular, higher levels of government offered minimal assistance and believed that public welfare was a local government responsibility. Women were key actors in the fight for better health care services. Specifically, it was largely in response to pressure from women's organizations that the liberal government of Alberta created a public health portfolio in 1918.[110]

---

[106] Ibid, 249-250.

[107] Palmer and Palmer, ***Alberta a new history***, 77.

[108] Susan Jackel, ***A Flannel Shirt of Liberty. British Immigrant Gentlewomen in the Canadian West 1880-1914***, (Vancouver: University of British Columbia Press, 1982), 123.

[109] Ibid, xxiv.

Edmonton: the hub of French Canadian settlers

Considering the object of this study, it is important to pay particular attention to the development of Edmonton, and to the role played by French Canadians in its growth. At the turn of the century Fort Edmonton had expanded outside its walls and the small town was destined to know the boom and bust cycles so common to Western Canada. The importance of Fort Edmonton in the fur trade industry had brought prosperity in the region, which was in large part populated by French speaking Catholic individuals who were served from 1854 on by the Fort's parish of St. Joachim. In 1877, St. Joachim's church was relocated outside the Fort and its surrounding area became the neighbourhood of the French speaking community.[111] Although the Canadian census compiled in 1884-85 does not provide figures for Edmonton itself, it gives data for the subdivision of Edmonton which included the town and the northern part of the future province. The area was populated by 5616 individuals, including 3,107 natives, and 2599 non-natives. Among the non-natives it was found that 1,522 individuals were of French origin (582 French Canadians and 940 Métis). Thus around 60% of the non-native population spoke French. It has been estimated that at the time the town of Edmonton had 300 residents of whom at least half were francophones.[112] According to MacGregor, in 1892 the newly incorporated town of Edmonton had 700 residents.[113] It is impossible to know if the French population had significantly increased between 1885 and 1892. Although people of French origin had immigrated to Edmonton, the aftermath of the Northwest Rebellion had pushed the French Métis further north.

In general, the growth of Edmonton had been slow during the 1880's and this stagnation has been associated to the absence of a railway link.[114] The construction of the Edmonton-Calgary line in 1891 gave hope to the residents. However, Edmontonians were disappointed when they realized that the CPR line would not cross the river and would end at Strathcona.

---

[110] This topic is further addressed in subsequent chapters.

[111] Hart, ***Ambitions et réalités***, 15.

[112] Ibid., 18

[113] James MacGregor, ***Edmonton, A history***, (Edmonton: Hurtig Publishers, 1973), 313.

It has been noted previously that an increasing number of settlers of British origins were coming to the province. They initially favoured the southern portion of Alberta but soon started to spread further north. The Catholic clergy, predominantly French speaking, was concerned by this immigration pattern. Bishop Taché understood that without concerted efforts the French Catholic population would be submerged by one which was English and Protestant.[115] Organized immigration was needed and colonization missionaries such as Jean-Baptiste Morin attempted to attract French Canadians from Quebec and the United States to immigrate to Alberta. The missionaries' efforts brought newcomers but immigration never reached the level which would have maintained the proportion of French speaking people in the Northwest at the level it was in the 1880's. A direct consequence of this low immigration flow was that in 1892 the territorial assembly revoked the legal rights of the French speaking population.[116]

In order to understand why few Quebecers[117] decided to go west, it is essential to examine what they believed was their country at the time, and what they considered to be the role of the Canadian Confederation. On the eve of Confederation, Quebecers "... had long been accustomed to thinking of themselves as a nation and of Lower

---

[114] Palmer and Palmer, ***Alberta a new history***, 62.

[115] Alice Trottier, ***Jean-Baptiste Morin - Journal d'un colonisateur, 1890-1897***, (Edmonton: Le salon de la francophonie albertaine, University of Alberta Press, 1984), xiv.

[116] Palmer and Palmer, ***Alberta a new history***, 67.

[117] To facilitate reading *Quebecer* is used instead of French Canadian from Quebec.

Canada [Quebec] as their country."[118] Using primary sources Silver demonstrated that they wanted the autonomy of their homeland and were "lured to believe" that Quebec would "constitute a state within a state."[119] In their minds, Confederation seemed to make official the fact that Quebec was distinct by virtue of its French Canadian nature and that it was the country of French Canadians. Likewise if Quebec was their country the rest of Canada was foreign territory to them. Much of the Quebecers' emigration patterns can be explained by this theory of the national vision.

It has been estimated that 500,000 Quebecers emigrated to the United States between 1860 and 1900.[120] For these emigrants, going south was a better choice than going west. In both cases they were leaving their country and the United States seemed to offer a better future. The majority of them were from rural areas where they had experienced much hardship. Thus, going to a country (the west) where agriculture was the main activity was not appealing while migrating to the industrialized New England where factory work and regular income were guaranteed was much more interesting. Thus, it is not amazing that the Catholic clergy from Western Canada had little success at convincing Quebecers who had decided to go to the United States or were already there that the West was a good alternative.

The dominantly held vision about what was Quebec also explains why priests from that province offered little support to their colleagues of the west. In fact, for much of the Quebec elite, emigration to Western Canada or to the United States was seen as the same calamity, a calamity that could only weaken the centre of French culture in

---

[118] Silver, ***The French Canadian idea of Confederation***, 218.

[119] Ibid.; Raymond, J.A. Huel, "Gestae Die Per Francos: The French Canadian experience in western Canada," in ***Visions of the new Jerusalem. Religious settlement on the prairies***, ed. Benjamin G. Smillie, (Edmonton: NeWest Press, 1983), 42-43.

[120] Jean Hamelin, ***Histoire du Québec***, (Montreal: Editions France-Amérique, 1977), 336; Susan M. Trofimenkoff, ***Visions nationales. Une histoire du Québec***, (Montreal: Editions du Trécarré, 1986), 187.

America.[121] Trying to control the exodus, the province developed its own colonization movement. Populating the Saguenay and Abitibi regions was thus seen as a way to keep the Quebecers in their country. It is clear that encouraging the colonisation of the west would have had the opposite effect.

Political events reinforced the notion that the rest of Canada was a foreign land where few advantages could be found. The execution of Louis Riel and the passage of laws which eradicated the rights of French speaking westerners made the area even less appealing. For Trottier, the *school question* was the greatest deterrent to the repatriation of Franco-Americans to western Canada.[122] It is doubtful that this question was the leading factor in the refusal of the Franco-American to come to Western Canada. However, it is very likely that it played a role. While the use of French was already prohibited in the Manitoba schools, Franco-Americans could have their own schools. The United States did not offer financial support for their schools but they at least did not forbid them.

It is evident that the French Canadian elite of the west had a different vision of what was French Canada and of what it could become. This elite believed that the establishment of a Franco-Catholic block in the west could enhance the position of their nationality in confederation.[123] It was thus difficult for them to understand the views widely held in Quebec. They also blamed the federal government who in their mind encouraged the immigration of Europeans while it did little to support their own colonization movement. Father Morin's writings illustrated well the situation:

> Malheureusement, le gouvernement canadien n'a jamais fait grand chose pour rapatrier les nôtres: les étrangers européens ont toujours la part du lion dans les faveurs de nos gouvernements. Nos amis des Etats-Unis qui sont venus s'établir

---

[121] Robert Painchaud, "French Canadian historiography and Franco-Catholic settlement in Western Canada, 1870-1915," ***Canadian Historical Review***, 59 (April 1978): 459; Owram, ***Promise of Eden***, 5-6; Silver, ***The French Canadian idea***, 140.

[122] Trottier, ***Jean Baptiste Morin***, xix.

[123] Painchaud, "French Canadian", 447.

> dans nos colonies ont dû payer tous leurs frais de déplacement, et Dieu sait ce que coûte une dizaine de billets de chemin de fer du Kansas, de Washington ou du Massachusset, à Edmonton.[124]

The failure of French Canada in colonizing the west meant that by the end of the 1800's French Canadians no longer comprised half of the population of the Northwest. The Western French Canadian Catholic clergy had found few allies in its battle to settle the West. However, it is clear that without their efforts, even fewer French Canadian would have come to the Prairies. In fact, after the death of Bishop Legal (the last francophone bishop) in 1920, many francophone priests left the province for good and the Franco-Albertans ceased to take an active interest in colonization.[125]

Although French Canadians also lost their majority status in Edmonton during the 1890's, their numbers steadily increased. Edmonton was their cultural, educational and political capital. When Alberta became a province in 1905, the French community was active in all aspects of the town's life. A large proportion of the social activities surrounded the Catholic Church and patriotic associations. The Edmonton branch of the "Société Saint-Jean Baptiste" (created in 1894) and its weekly newspaper "L'Ouest Canadian" were flourishing.[126] French Canadians were represented on the town council and were actively involved in provincial politics. In 1913, at the peak of their influence five of the 56 members of the provincial legislature came from their ranks.[127]

French Canadians were particularly involved in health care and through religious orders they founded two hospitals: the Edmonton General Hospital and the Misericordia Hospital. These hospitals were created at timely moments, and their evolution was linked with the growth of the capital. Needs for health care services were partly linked with population increases resulting from phenomena such as the discovery in the 1890's of gold in the Yukon Territory. During the gold rush, Edmonton's population doubled overnight, and although most of the newcomers only considered the town as a transit, a large number of them eventually settled in the area. In 1905, when the province was created, Edmonton had 11,400 residents (including the population of Strathcona) and it welcomed the Canadian Northern Transcontinental Railway which would further contribute to the growth of the city.[128] Although French Canadians had lost their majority status, they contributed throughout the following decades to the expansion of hospital services. The Grey Nuns of Montreal played an active role in this expansion and their involvement in addressing health care needs must be examined.

---

[124] Quote translation: Sadly, the Canadian government has never done much to repatriate our people; strangers from Europe always receive the lion's share of the government favours. Our friends from the United States who came to our colonies had to pay the entire cost of their move, and God knows the cost of ten train tickets from Kansas, from Washington or from Massachussets, to Edmonton. From a letter of Jean-Baptiste Morin to the Director of the newspaper *Le Monde*, December 1896. This letter was reproduced in Trottier, ***Jean-Baptiste Morin***, 133.

[125] Trottier, ***Jean-Baptiste Morin***, xxi.

[126] Hart, ***Ambitions et réalités***, 34; Palmer and Palmer, ***Alberta a new history***, 90.

[127] Hart, Ibid.

---

[128] Palmer and Palmer, ***Alberta a new history***, 137-139.

CHAPTER 5

THE BIRTH OF AN INSTITUTION: 1894-1895

The purpose of this chapter is to present the events which led to the creation of the EGH in 1895. Prior to that date, Edmonton did not have any hospitals while Calgary already had two. Since 1883, the southern portion of Alberta had been served by the Canadian Pacific Railway (CPR). The presence of the train is an important factor in understanding why Calgary grew much faster than Edmonton. This more intense growth led to the establishment of the Calgary General Hospital in 1890. Soon after, a second hospital was built in the booming town. In 1891, at the request of Bishop Grandin, the Grey Nuns founded the Holy Cross Hospital. The creation of that hospital occurred because the Roman Catholic clergymen believed that the religious needs of their worshippers were ignored at the municipal hospital.[129] Fortunately, in 1891 the CPR established a service line between Calgary and Edmonton. Edmontonians had mixed feelings about the new line because it stopped in South Edmonton, which at the time was still an independent municipality and one that offered real competition to the city on the north bank of the North Saskatchewan. Still, the benefits of the railway were felt on both sides of the North Saskatchewan and Edmonton experienced its first significant period of rapid growth. In 1892, Edmonton became incorporated and the census done on the occasion revealed that the municipality had 700 residents.[130] Two years later the population reached 1,021 individuals.[131]

At that time, Edmonton citizens who needed hospital care had to go to St. Albert where the Grey Nuns operated a mission hospital. This situation was cumbersome for patients as well as for physicians who were forced to continuously commute between the two locations. St. Albert was only a few miles away but with the modes of transportation of the time it was still quite an expedition to reach the Catholic Mission. Consequently, considering the transportation difficulties and in view of the fact that

---

[129] ASGME, Holy Cross Hospital, Souvenirs of the Golden Anniversary of the Holy Cross Hospital, 1941, 4-5.

[130] Edmonton City Archives (ECA), population statistics.

[131] Ibid.

Edmonton's population had increased enough to justify the creation of a hospital, six physicians forwarded a request to Bishop Grandin on April 25, 1894:

> We the undersigned medical practitioners of the Town of Edmonton do hereby agree that we will do all that is in our power to support a general hospital built by the Grey Nuns in the town of Edmonton; and that we will agree to support it to the exclusion of any other Hospital, provided that it be built this year with accommodation in proportion to the size of the town and that it be run as a general hospital under the management of the sisters without a resident doctor. Signed by H.C. Wilson, H.L. McInnis, P.S. Royal, J.H. Tofield, J.D. Harrison and E. A. Braithwaite.[132]

Three days later Bishop Grandin sent this reply:

> Quoique n'ayant aucune autorité directe sur l'administration temporelle des Révérendes Soeurs de la Charité, je me fis un devoir de prendre votre bonne lettre en considération. En conséquence, j'écris aujourd'hui même à leur Supérieure Générale pour la presser d'accepter l'établissement d'un Hôpital Général à Edmonton et de donner des Soeurs qualifiées pour cette oeuvre. N.B. Cet hôpital devra être proche de l'église catholique.[133]

The letter of Bishop Grandin to Mother Deschamps revealed that on the 8th of March, they had already discussed the idea of building a hospital in Edmonton and that he was then opposed to the project. However, he had reconsidered his position and by April 28, he was favouring the venture.[134] It is suggested that Bishop Grandin may have been convinced by the physicians that the citizens and the town council would offer much support to the institution. The rationale he presented to convince the Superior General suggest that she too was initially opposed to the project. Bishop Grandin wrote:

---

[132] ASGME, Edmonton Hôpital Historique (EHH), Doc. 6. Letter of the physicians of Edmonton to Bishop Grandin, Edmonton, 25 April 1894.

[133] Quote translation: Although I do not have any direct authority over the administration of the Reverend Sisters of Charity, I considered it my duty to inform the Superior General to entreat her to undertake the establishment of a hospital in Edmonton, and to provide qualified Sisters for this work. N.B. This hospital will have to be close to the Catholic Church. ASGME, EHH, Doc. 8, Letter of Bishop Grandin to the Physicians of Edmonton, St. Albert, 28 April 1894.

[134] ASGME, EHH, Doc. 9, Letter of Bishop Grandin to Mother Deschamps, St. Albert, 28 April 1894.

> Mais vous me direz ma mère qu'il faut de l'argent pour cela. Sans doute ma Mère, il en faut, et sachant combien vos filles sauront économiser et conduire les affaires, connaissant les dispositions des habitants d'Edmonton, je ne craindrais pas d'emprunter les sommes voulues, convaincu que les Soeurs pourront payer des intérêts raisonnables et acquitter le capital en peu d'années. Soeur Carroll est loin d'être dans une position aussi avantageuse qu'à Edmonton, et tout en se plaignant, elle paye les intérêts de sa dette et diminue le capital.[135]

Sister Carroll was the Superior of the Holy Cross Hospital and the difficulties experienced at that institution were probably the main motive why the Superior General was opposed to the creation of a hospital in Edmonton.[136] But Edmonton and Calgary were different. Edmonton did not have any other hospital; thus a Grey Nuns' hospital would not be seen as competition, and more important, the population of Edmonton was far more Roman Catholic and French Canadian than the population of Calgary. In addition, the Grey Nuns had been in the area of Edmonton since 1859 and they had established a sound reputation.

It is obvious that the population of Edmonton supported the plan proposed by the physicians since 850 individuals petitioned the Town Council to financially assist the

---

[135] Quote translation: "However, you will tell me that it is necessary to have the funds to do this. Undoubtedly it is necessary my Dear Mother, and knowing how much your daughters will know how to economize and manage their affairs wisely, and knowing the good dispositions of the Edmonton's citizens, I would not be afraid to borrow the necessary sum, convinced that the sisters will be able to pay reasonable interest and pay down the capital within a few years. Sister Carroll is far from being in such advantageous position as in Edmonton, and although she is complaining about her situation, she is paying interest on the debt and reducing the capital." Ibid.

[136] The majority of the people of Calgary had been opposed to the creation of a second hospital. ASGME, EHH, Doc. 19, Letter of Sister Carroll to Sister Brassard Superior of St. Albert, Calgary, 12 June 1895.

Grey Nuns.[137] The number of petitioners was remarkable considering that Edmonton only had 1,021 residents in 1894. The petition was presented to the Town Council on August 23, 1894. Right after the meeting, Father Lacombe who spoke at the event and who had encouraged a local lawyer to circulate a petition, immediately wrote to Mother Brassard, the Superior of St.Albert, to inform her that the town had agreed to give financial support.[138] At the next council meeting "... it was moved by J.H. Picard and seconded by C.F. Strang" that in answer to "the prayer of the Petitioners, that a grant of $1000.00 be given towards the erection of a General Hospital."[139]

By then negotiations for land purchase were already under way and on October 29, 1894, the Corporation of the Sisters of Charity of the North West Territories decided to buy 45 lots from the Hudson Bay Company for the sum of $2,300.00.[140] Construction began the following Summer. In July 1895, Sister Marie-Xavier from St. Boniface Hospital (Manitoba) who would be the first superior of the EGH, and Sister Gosselin from Montreal arrived in Edmonton.[141] By the first of November, the progress made in the construction of the hospital was sufficient to allow the sisters to live in the building. They moved that day and had their cooking stove transported to the hospital. According to the chronicles the stove was damaged in the move and from then on produced "enough smoke to make a cat cry."[142] Five days later Sisters Coursol and Saunders joined their two colleagues. Both sisters were from Quebec and had spent some time at the St. Boniface hospital.

---

[137] ASGME, EHH, Doc. 11, Letter of Edmonton citizens to the Town Council, 22 August 1894.

[138] ASGME, EHH, Doc. n.n., Letter of Father Lacombe to Mother Brassard, Edmonton, 23 August 1894.

[139] ASGME, EHH, Doc. 15, Letter of Mr. Rawdall from the Town Hall to Mother Brassard, 8 September 1894.

[140] ASGME, EHH, Doc.18. Letter of Mother Brassard to C.C. Chipman of the Hudson Bay Company, St. Albert, 29 October 1894. Sisters of Charity of the North West Territories was the corporate name of the Grey Nuns. This corporation was established in 1882. Government of Canada, Statutes of Canada, (Ottawa: Author, 1882).

[141] ASGME, EGH, Chroniques, 28 July 1895.

From the time of arrival at the EGH and for many months thereafter, the four sisters were provided most of their food by the Grey Nuns of St. Albert.[143] However, on November 6, the first step towards their autonomy arrived from the mission: a cow was given and it was the beginning of a little farm that would be established on the hospital's grounds.[144] The data entered in the hospital ledger showed that in November and December 1895, the sisters received the equivalent of $22.95 in food from the St. Albert Grey Nuns. The records show that meat must have been a very important aspect of their diet since they received 50 pounds of pork ($2.50), 40 pounds of beef ($1.60), two turkeys and six chickens ($3.50). Eleven dozen eggs were also given as well as 50 pounds of flower and many pounds of bread, butter, lard, and vegetables (cabbage, carrots, potatoes and turnip). Tea, coffee and jam completed the list.[145] The Oblate priests and individuals from Edmonton also donated small quantities of food. Some long term goods were provided by other benefactors. For example, the afore mentioned stove was given by Ross and Brothers General Store, the architect donated the chapel's altar and Mrs. Gariepy offered a table cloth.[146]

On December 18, 1895, the hospital was blessed by Mgr Langevin from St. Boniface, Mgr Grandin from St. Albert and Mgr Grouard Apostolic Vicariate of the far north.[147] The same day three additional sisters arrived at the EGH. These newcomers completed the staff (seven nuns) of the newly built 36 bed hospital. The first patient had already been admitted the previous day.[148]

---

[142] ASGME, EGH, Chroniques, November 1895.

[143] ASGME, EGH, Chroniques 1895 and 1896.

[144] Received on November 6, 1895, one cow and two loads of hay, value: cow ($20.00) and hay ($8.00). ASGME, Hôpital Général, Livre de caisse 1895-1939, dons en nature.

[145] Ibid.

[146] Ibid.

The new hospital was a big building for a small town like Edmonton. The architect, Mr. J.A. Senécal, was a Franco-Manitoban who had previously worked for the Grey Nuns.[149] The building was made of brick and wood and by its modified classical and Victorian styles it had many characteristics of the large houses of Montreal. The pointed roof with small gables was typically French Canadian.[150]

The first floor had two wards and two private rooms for women. Also on that floor were two lounges for patients' and visitors' use, and the hospital pharmacy. Men had the same accommodations on the second floor except that one lounge was assigned to smokers. The wards of both floors had seven beds. The operating room, a private room and a dressing room were located on the third floor. The sisters' bedrooms as well as three isolation rooms were between the third floor and the mansard roof. A water tank of 1,500 gallons was further up in the same part of the building. A two storey wooden extension was attached to the main building. The first floor had refectories, kitchen and laundry services. It is conjectured though that employees' living quarters were located on the second floor of that building.[151] As with all other buildings of the day, the hospital used hot water heating and the boilers were located in the basement of the main building. A stable measuring 26 by 38 feet was built under the same contract. The total cost of the construction was $30,000.00. Thus the Grey Nuns had invested $31,300 towards that first building including the cost of the land and deducting the town contribution.

---

[147] ASGME, EGH, Chroniques, 18 December 1895.

[148] Ibid.

[149] He had built the hospital of St. Boniface and the Holy Cross Hospital of Calgary. Estelle Mitchell, ***Les Soeurs Grises de Montréal à la Rivière Rouge, 1844-1984***, (Montreal: Editions du Méridien, 1987), 163.

[150] Edward S. Hart, ***Ambitions et réalités, la communauté francophone d'Edmonton, 1795-1935***, trans. G. Lacombe and G. Allaire (Edmonton: University of Alberta Press, 1981), 43.

[151] The purpose of that floor was not given in the description. ASGME, EGH, Chroniques, 1895.

The last significant event of the year was the creation of the *Ladies Aid Society* on December 21, 1895. Elections were held and Mrs. E.A. Braithwaite was elected president, Mrs. H.E. Lauder vice-president, Mrs. N.D. Bech secretary and Mrs. S. Larue treasurer. The husbands of at least three of these ladies were prominent members of the community. The president was the wife of Dr. Braithwaite, the secretary was married to lawyer Bech, and the treasurer to the owner of a major general store.[152] Forty-one women were members of the society. A youth branch was also formed the same evening. The ladies decided that they would meet once a month to knit, sew and make crafts and that the profits made by selling these items would be given to the hospital. A few days after the creation of the organization, the ladies held the first fundraising event and a profit of $322.75 was made.[153]

Although the official opening of the EGH only took place on February 6, 1896, by the end of December 1895, the hospital had already admitted 31 patients.[154] The support of citizens had been displayed by individual donations, and the organization of a Ladies Aid society whose first benefit evening had been a clear success. Notably, the *Edmonton Bulletin* had published a feature article in which the hospital had been described.[155] No doubt, the opening of a first hospital was an event for the little town of Edmonton, and the future of the institution looked rather promising.

---

[152] ASGME, EGH, Chroniques, December 1895; Hart, ***Ambitions et réalités***, 29.

[153] ASGME, EGH, Chroniques, December 1895.

[154] Sr Ann Ell, ***Edmonton General Hospital, 90th anniversary publication***, (Edmonton: EGH, 1985), 7.

[155] ASGME, Newspapers file, ***Edmonton Bulletin***, 21 December 1895.

CHAPTER 6

THE TERRITORIAL YEARS: 1895-1904
ADMINISTRATIVE DIFFICULTIES: WHO SHALL BE IN CHARGE THE SISTERS OR THE PHYSICIANS?

This chapter and the subsequent four are devoted to the administration of the hospital. In order to accomplish this in a meaningful way, the 75 years under study have been divided into five eras, each of which is examined in a separate chapter. The first period extends from 1895 to 1904 and corresponds to the first ten years of the institution, a period during which Alberta was still part of the Northwest Territories. The second period (Chapter 7) spans the period from 1905 to 1918. Thus it begins with the creation of the province and is concluded by the end of World War I (WWI). The third period (Chapter 8) covers the between war years of 1919 to 1938. The fourth era (Chapter 9) spans the years from 1939 to 1957. It begins with World War II (WW II) and ends with the implementation of the national hospital insurance plan. Finally, the fifth period (Chapter 10), 1958 to 1970, corresponds to the years in which provincial and federal involvement in health care culminated in the inclusion of medical care in a national health care insurance program.

In each of these chapters, the administration of the hospital is studied by considering four major themes: administrative structure, administrative issues, sources of financial support and budget. It is apparent that during each of these periods of time, administrative decisions reflected events affecting the society in which the EGH was evolving. In particular, construction plans were a function of the general economic climate, and of the growth of Edmonton and its other three major hospitals. In general, the hospital's sources of financial support reflected the changes which took place in respect of health care policy making, as well as the economic conditions of each era. It is suggested that availability of funding was a key factor in choosing what type of services were offered to the population. Finally, the results presented in these chapters show that administrative decisions were shaped by the internal administrative structure of the Grey Nuns' Order, by the values and beliefs of the sisters about health care and hospital administration, by the availability of religious personnel, by the growth of standardization in the hospital world, and by government policies.

The results of the present chapter show that the sisters operated under an administrative structure that was established by the Motherhouse and that the EGH structure was parallel to that of other hospitals operated by the order in Montreal. The sisters had a firm grasp of administrative policy-making and some of the practices that were established went against the will of a number of physicians. One such conflict led to the creation of the Edmonton Public Hospital (EPH) later known as the Royal Alexandra Hospital (RAH). The conflict created much turmoil and the birth of the EPH brought competition as well as financial difficulties to the EGH. However, the institution survived and by 1904 the sisters were hopeful again.

Administrative structure of the hospital and of the Grey Nuns' Order

During this era the hospital administrative structure was minimal. The Superior was in charge and she had absolute control over the daily administration of the hospital. She was assisted by another sister, the "Assistant Superior". However, important decisions had to be approved by the Provincial Council which was constituted of the Provincial Superior and a number of assistants. For major decisions, approval had to be obtained from the Montreal Motherhouse. Individual appointments of sisters were determined in Montreal by the Superior General and her council. The Superior General had the power to appoint or revoke a local superior. However, like in other hierarchical structures of the Roman Catholic Church, the Superior General was elected by her peers, the provincial superiors.

Being under canonical law, the Grey Nuns reported directly to the Pope. Quinquennial reports were therefore sent to the Vatican and the approval of Rome was necessary for major decisions, such as the borrowing of very large sums of money.[156]

---

[156] Prior to 1873, the Grey Nuns' Order had been diocesan. This status had created jurisdiction conflicts, as each house had to report to the bishop responsible for the geographical area in which it was located. Specifically these conflicts amongst bishops had led to the separation of the Quebec and Ottawa houses from the Motherhouse. One of the most important advantages of being a canonical order was that it eliminated the diocesan level of authority and thus guaranteed that new foundations remained under the Motherhouse.

Because of the direct link with the Vatican, the local bishop did not have direct authority over the sisters' administrative decisions.[157] However, in practice he was occasionally consulted especially if obtaining his support was deemed advantageous. For example, when proposals were sent to Montreal, the support of the local bishop was considered in judging the advisability of a new development.

Administrative issues

Physicians versus sisters

The most significant administrative issue of the period began in 1899 when a conflict arose between the physicians and the Grey Nuns. However, analysis of the data related to the case demonstrates that part of its seeds could be found in the initial regulations that had been established in 1896. In January of that year, the hospital's admitting policies had been printed in the *Edmonton Bulletin*:

> Be it well understood that the hospital has nothing to do with paying the medical men; all patients, who have not the means of paying a Doctor, will be under the care of the Physician of the month; all who pay, can have any Doctor they may chose. [...] To them [the Grey Nuns] alone belong the right to determine the different offices to be filled by the Sisters and employees, to engage the necessary help and to watch over the perfect working of the Hospital. The Hospital [...] is open to all patients without distinction of belief, religion or nationality.[158]

The rules had thus been clearly set. However, on January 30, 1899, it was reported in the *Edmonton Bulletin* that Doctors Wilson, Harrison, Braithwaite and McInnis had resigned from the EGH. The same day the *Bulletin* announced that a committee had been established to consider the creation of a civic hospital and that population support would be sought.[159] On February 2, 1899 the Grey Nuns published in the same newspaper that: "The fact is that the medical directors have resigned the obligations which they had voluntarily and kindly taken upon themselves to attend pauper patients for the space of a month alternatively. Such being the case, the hospital authorities will see that pauper patients are not neglected, but rather received and cared for in the hospital as before; at least as long as the Sisters of Charity have the means to do so."[160] The same week, they also printed a similar article in the local French Canadian newspaper.[161]

---

[157] The local bishop did have authority over matters related to religious issues.

[158] ASGME, Newspapers file, ***Edmonton Bulletin***, 10 January 1896. Also included as a matter of principle was the fact that ministers of other denominations were welcome to visit the patients of the same faith.

[159] ASGME, EHH, Doc. 58, ***Edmonton Bulletin***, 30 January 1899.

On 9 February 1899, the Grey Nuns published in the *Edmonton Bulletin* what they considered to be the reasons behind the physicians' departure:

> The doctors have resigned their alternate monthly attendance of pauper patients because they were not satisfied with the answers received from the Rev. Mother General of the Sisters of Charity, to the following resolutions passed by them last December:
>
> 1- That no charity patients are to be admitted without an order from the doctor for the month, or an order from a member of the medical board.
>
> 2- That no private patients be admitted to the hospital without the order of a doctor who shall be in charge of the patient, or if any private (paying) patient desires admission such patient shall have the doctor of the month.
>
> 3- That in the event of an emergency case, a patient may be admitted without a doctor's order, but that such case must be clearly one of great emergency, and in such case the doctor for the month shall be immediately sent for, and he shall have charge of such case, or in the event of the doctor of the month not being available, the assistant shall be sent for, and in his absence any other member of the board.
>
> 4- That no pauper maternity case be admitted.
>
> 5- That a book be procured to be kept in the doctors' room, in which the doctor

---

[160] ASGME, Newspapers file, ***Edmonton Bulletin***, 2 February 1899.

[161] ASGME, EHH, Doc. 58, ***L'Ouest Canadien***, 6 February 1899.

admitting a patient shall enter his or her name and certify as to the standing of each patient, if private, pauper, diagnosis, date of admission, discharge, etc...

6- That the rules and regulations in regard to the admission of patients and general management of the hospital be printed.

The article also included the directives of the Superior General to the EGH Superior in respect of the physicians' requests:

> To #1 - I answer that having been appointed by the community, superior of the hospital, you have the right to admit or not pauper patients, if you have good reasons to do so. In a large country as yours, how can you expect a poor patient already tired out by a long trip to go around the town to get a doctor's note? I noticed the fact while with you last summer.
>
> To #2 - You have the same right for admittance or not of private patients, and such patients are at liberty to have a doctor of their own choice, you cannot interfere in the matter. Any regular qualified medical practitioner may have patients in our hospitals.
>
> To #3 - In an emergency case, it is well to notify the doctor on duty. In his absence get the nearest doctor you can.
>
> To #4 - The question for maternity cases not being finally settled nothing is to be said on the subject. You will consequently act according to my private instructions, as you have already done.
>
> To #5 - During my inspection in June, I found your records concerning the patients kept in the manner used in our hospitals, and in very good order. I consider that this work should remain in your hand.[162]
>
> To #6 - I saw at the entrance of the hospital, in the different wards and private rooms, proper regulations in printed form giving clear information to every one

---

[162] In May 1898, the Superior General had done a canonical visit and had written in the book used to that effect that all rules were respected and that all records were well kept. ASGME, Hôpital Edmonton, Visites canoniques 1896-1953. May 1898, 10-11.

concerned.[163]

Further evidence shows that the conflict amounted to a power struggle over matters that physicians considered to be in their particular domain. Specifically, they thought that controlling admissions was within their realm of responsibilities. However, one might suspect that monetary issues may also have been an important factor. Indeed having to serve as physician of the month was far from lucrative. The sisters decided not to back down and to retain their authority over patient admissions. However, the fight was not over and the *Edmonton Bulletin* became the battle field.[164]

At a public meeting held on March 21, 1899, the physicians reported that the sisters might unknowingly admit infectious cases to public wards. They also stated that they had resigned because "... while having to assume responsibility of the case and attention of the so-called patients, no matter how admitted, we had no authority or say in the admission, management, nursing or discharge or general work of the hospital. [..] We did not agree to attend to a private hospital or an institution as Father Leduc told us was more than a hospital."[165]

On April 10, 1899, Father Leduc published what he called:

> The logical inferences to be deducted from the physicians' statements:
>
> The right of the admission of patients in the general hospital has been a secondary pretext used by the doctors; the true reason of the disagreement is now clearly to be found in [...] their statement when they say they have no authority in the management, nursing or discharge or general work of the hospital. But have they not asked for a general hospital to be established, built and maintained by the Sisters of Charity. Were they not expected (the Sisters of Charity) to conduct the institution according to the rules of their order and the regulations of the civil

---

[163] ASGME, Newspapers file, ***Edmonton Bulletin***, 9 February 1899; the same day an identical French version appeared in ***L'Ouest Canadien***.

[164] Surprisingly Edmonton resident did not use the press to state their opinion about what they were reading.

[165] ASGME, Newspapers file, ***Edmonton Bulletin***, 30 March 1899.

> corporation? Have the doctors any complaint to make against the administration, nursing and general work?
>
> The step taken by the doctors was, as it is plainly affirmed in their statement, not because the hospital was sectarian, but because it is not and never has been a general hospital; at least they say so. Well, I confess that I am at loss to understand what is meant by such an assertion. A hospital open to every one, without distinction of race, nationality, religious belief, to any minister of religious denominations, to any qualified doctor, etc..., deserves most certainly the title of a general hospital. Shall it lose this title because it is the property of a corporate body or because it costs comparatively nothing to the town in which it is located. The Corporation of the Sisters of Charity spent over $35,000.00 themselves as against a comparatively very small amount kindly given by the municipality!
>
> Because the sisters have sometimes given shelter and help to the poor or destitute persons, who will disapprove of this act of charity and humanity? Because they also sometime receive, not as patients, but as private boarders, some persons who want either rest or special nursing, are they to be blamed for it? And are these persons to be referred to a doctor when they neither want or need any?
>
> Sisters of Charity who for many years have assisted doctors, filled and studied their prescriptions attended all kinds of sickness, consulted duly authorised medical books, etc... have at least enough experience and medical knowledge to suspect a case of contagion or epidemic. The doctors' objection, is more apparent then real, and I would cite a case pronounced to be likely erysipelas by the sisters when the doctors affirmed the contrary and ordered the patient put in a general ward, but were obliged to have him isolated on the following day. The sisters' suspicions had proved to be reality."[166]

Events of 1897 suggest that Father Leduc was probably right when he concluded that what physicians were really after was greater power. In June 1897 the following was noted in the chronicles: "the physicians are very good to us and they show satisfaction in the patient care we give. However, they would like to have more power in the hospital they like to call OUR HOSPITAL. To this effect they attempted to negotiate a city grant of $500.00 per year."[167] The chronicler also mentioned that Sister Marie-Xavier (superior) had informed Mother Deschamps (Superior General) of the physicians' initiative. Mother Deschamps responded that obtaining $500.00 of the town was not worth the problems it would create by imposing a link which would lead to a loss of independence. If the hospital had accepted the grant, a board of directors would have had to be created and the members of such board would have been selected by the city. Mother Deschamps concluded her letter by: "Nous sommes chez nous, nous y demeurerons maîtresses et indépendantes. Nous n'avons pas besoin de bureau de directeurs pour nous conduire et contrôler. [...] Quand les protestants ont un pied, ils ont bientôt mis les deux, avec tous leurs bureaux de directeurs et de visiteurs."[168] It appears that the physicians dropped the matter but as showed by the events of 1899, it was only a question of time.

---

[166] ASGME, Newspapers file, ***Edmonton Bulletin***, 10 april 1899.

The power struggle between the male physicians and the female nursing sisters rings a familiar chord, and the fact that the event occurred prior to the legal constitution of nursing as a profession and prior to the declaration that Canadian women were "persons" makes the sisters' resistance even more interesting. The words of the Superior General left no doubt about who was in charge in Grey Nuns' hospitals. However, the struggle for power was not without negative consequences for the EGH. The conflict resulted in the creation of a competing hospital. On February 2, 1899, through the efforts of the physicians involved in the dispute assisted by the local Protestant clergy, the town council decided to establish the Edmonton Public Hospital (EPH), which was to be a non-sectarian institution.[169] The use of the term non-sectarian is most captivating. It is true that the EGH was a Roman Catholic hospital. However, it had always admitted patients from other denominations.[170] Further, the composition of the EPH board suggests that it was as Protestant as the EGH was Catholic. It is also significant that the Masonic Lodges were among the first to offer financial support to the EPH as it developed.[171]

---

[167] ASGME, EGH, Chroniques, 17 June 1897.

[168] Quote translation: "We are in our house, we will stay independent and continue to be the masters of this house. We do not need a board of directors to rule and control us. [...] We must keep our rights. When protestants have a foot in a place, soon they will have both feet in, with all their boards of directors and visitors." Ibid.

Evidence suggest that the conflict indeed had had religious overtones. A letter published in *L'Ouest Canadien* is most revealing.[172] The author commented on an editorial that had appeared in a local newspaper in which it was stated that: "Everyone must oversee the religious interest of patients, because if they go to the Edmonton General, which is under the Grey Nuns control, their faith will be in danger, since that hospital is sectarian." The author of the letter to *L'Ouest Canadien* wrote that he believed that an occult force was at play and "that people who wish to build another hospital can do so but at their own expense. We protest against the idea to have to pay for the support of another hospital." The composition of the medical staff who did not resign from the EGH indicates that religious/cultural elements played a role. Of the original group of five physicians two remained: Dr. Tofield and Dr. Royal. Also remaining were the two physicians who had joined the hospital in 1896: Dr. Roy and Dr.

---

[169] Edmonton City Archives (ECA), 1BT.E24h. Edmonton Public Hospital Board Minutes, 1899-1939. Minutes of the meeting at the house of Reverend H.A. Gray, 2 February 1899.

[170] ASGME, EHH, Doc. 4. For example, in 1896 the EGH had admitted 494 Catholics and 450 Protestants.

[171] ECA, Doc. 1BT.E24h.

[172] ASGME, EGH, Chroniques, 1900, included a copy of an anonymous letter published in *L'Ouest Canadien*. The date of publication could not be identified and the unavailability of this newspaper made it impossible to trace the original. However, since the chronicles contained *verbatim* copies of the original articles that had been published in the *Edmonton Bulletin* there are no reasons to believe that the aforementioned letter was not meticulously transcribed. The letter referred to another article which could not be traced either.

Whitelaw.[173] The religion of the physicians who left and of those who stayed could not be determined. However, the two French Canadians (Roy and Royal), were both Roman Catholics. It is logical to propose that for them the sisters' authority was natural and acceptable. Both men had studied medicine in Quebec. At the time all hospitals which served the French Canadian population and were affiliated with medical programs offered in the French language were owned, controlled and operated by Roman Catholic sisterhoods. None of the dissidents were French Canadians. Because of their British origins, it is likely that many of the dissidents were educated in hospitals operated by municipalities or male boards of directors. For them the fact of authority resting on the shoulders of an entirely female administration was probably quite hard to accept if not simply aberrant.

The creation of the EPH was an enormous blow for the Grey Nuns, especially when considering the financial climate of the late 1890's. The sisters certainly did not need a competitor. To add to their misery, the town council informed them in January 1900, that from then on they would have to pay taxes like any other private business, and that since a new hospital had now to be built it would no longer be able to offer financial assistance to the EGH.[174] In this time of hardship the sisters relied on Providence and particularly on St. Joseph, the Virgin Mary, and Mother d'Youville. Indeed, faith was almost all what they could count on.

Ironically, it took a smallpox epidemic to bring back the sisters into the "good books" of the town council. If it had not been for the Grey Nuns, assisted by Dr. Royal and a nurse from the also Catholic Misericordia Hospital, those affected by the disease would not have had any medical or nursing care. Following the epidemic the town council revised its position about property taxes and gradually began to offer some financial assistance to the EGH.[175] Although the amounts were small they were appreciated and for the Grey Nuns the fact that autonomy had been preserved was much more important than the amount of money received from the city.

---

[173] ASGME, EGH, Chroniques, 1896.

[174] In 1897, the EGH had obtained the privilege of being exempted from paying property taxes. ASGME, EGH, Chroniques, 1897 and 1900.

[175] Ibid., 1901.

Other administrative issues

In September 1896, a delegate representing the Superior General came to the EGH for the first canonical visit.[176] She found that the Order's rules were followed but that there were some practices which were contrary to the regulations in the Montreal hospital. She noted: (1) there is no filing system to keep important letters such as those received from the city council or governments; (2) physicians come and go as they please without being accompanied by a sister; (3) some poor children are admitted to facilitate their attendance at local schools and they are fed in the hospital's kitchen; (4) the accounting is well done, however, the financial situation is poor and quite worrisome. Daily expenses are rarely paid on time, let alone payments on the construction's debt.[177]

A few weeks after the visit, the Superior General sent a letter listing the changes that would have to be made. She wrote: (1) a filing system will be organized; (2) physicians' arrival will have to be announced by five "rings". They will first go to the pharmacy where a pharmacist will take them to each unit. The pharmacist will carry a large book in which she will make all physicians write their orders. Immediately after their departure she will fill the orders and make sure that all medications are administered; (3) each purchase will be kept in an account book which will include details about dates and payments; (4) the practice of admitting poor children will be stopped. The institution is a hospital and should be for those in need of hospital care.[178] The canonical report of the following year revealed that the directives of the Superior General had been followed. In fact, none of the reports of the following years included indications that rules were transgressed.

---

[176] Canon law prescribes that the Superior General or her delegate visits all houses of the Order once a year. Verbal communication, Sr F. Champagne, SGM, archivist. The reports of canonical visits were kept in a small bound note-book. The content consists of a report of the visitor followed by recommendations and signatures of the local Superior and of her assistant(s). During these visits the Superior General or her delegate interviewed all sisters and discussed with the local Superior and her assistant(s). All books and records were also examined.

[177] ASGME, Hôpital Edmonton, Visites canoniques 1896-1953, Report of the visit of Sr. Christin, 7 September 1896, 4-7.

The report of the 1896 visit is very significant in terms of hospital history in North America. The content of this report suggests a strong interest in standardizing practices across the Grey Nuns' hospitals. By specifying that she had found differences between Montreal and Edmonton the visitor implied that differences were not acceptable. This is not surprising considering the strict rules governing religious orders in that era. However, since canonical visits or an equivalent existed in all Roman Catholic hospitals it is not surprising that after the results of the Flexner Report were published that these hospitals readily demonstrated interest in hospital standardization. It is thus understandable that they were approached before other types of hospitals by the American College of Surgeons when it was trying to organize a hospital accreditation program.

That the Superior General was opposed to the admission of children as boarders is an excellent indicator of the changes which were gradually taking places in North American hospitals. During the 1890's the role of the hospital as a general shelter was being eroded while its mission in respect of the treatment of the sick was becoming the key element. Thus, the reaction of the Superior General to the admission of school children reflected the new trends of the era. In other words the Grey Nuns' Motherhouse recognized that the hospital should be a treatment centre. Similarly, statements made by some of the physicians in 1899, suggest that they also subscribed to the new vision of the hospital as a treatment centre. It is also clear that a power struggle was central to the conflict between the physicians and the sisters. Key to this struggle was that although both opponents recognized that the hospital should be a treatment centre, they did not share a common definition of what constituted such a centre. For medical practitioners a treatment centre had to be a "physician's workshop"[179], a place where patients were admitted for medical reasons and where nurses provided care to patients whose primary problems were of a medical nature. For the sisters, a treatment centre was not exclusively devoted to medical problems, it was also a "nurse's workshop". When Father Leduc wrote that the need for nursing care could justify hospitalization, he gave a clear indication of the importance given by the sisters to the nursing workshop component of the hospital.

---

[178] Ibid., 1 October 1896, 8.

Nursing care has always been a component of the hospital. However, what is perceived as nursing and as appropriate forms of nursing care delivery in the hospital has changed over time. The impact of the publication of the first nursing literature, and the creation of the first nursing schools in the second half of the nineteenth century cannot be ignored when trying to understand the evolution of nursing in the hospital world. For the first time, definitions of nursing and of what constituted the scope of the field were being elaborated. The Grey Nuns were aware of the changes which were taking place in nursing in the rest of North America and in the United Kingdom; for example, in 1898, they followed the trends in nursing education and opened a school of nursing at *l'Hôpital Notre-Dame* in Montreal. Although it was not possible to find documents in which the Grey Nuns presented their vision of nursing, the events which occurred at the EGH between 1896 and 1899 suggest that they had a vision and that they believed that nursing care did not always have to be linked to medical care. In light of the outcome of the 1899 crisis, it can be suggested that nursing as an independent service from medicine continued to be offered at the EGH. However, this form of nursing disappeared over the succeeding decades. The exact time could not be determined but it is suggested that the creation of schools of nursing in the network of Grey Nuns' hospital contributed to the loss of independent nursing activities.[180]

---

[179] The term *physician's workshop* is borrowed from Charles Rosenberg, ***The Care of Strangers***, 271.

[180] It is believed that the prominent role played by physicians in nursing education at the turn of the twentieth century had a negative effect on the development of nursing as

Hospital inspection

The first available information about an inspection from the Territorial authorities was written in 1901. The inspector commented that: "The hospital was scrupulously neat and clean and there were no complaints."[181] In 1903, the same inspector showed satisfaction; however, he wrote: "With the very large number of people which are now crowding into the Edmonton district, the accommodation of this hospital is bound to be taxed to its utmost, and although it is a matter with which, I perhaps have little concern, I think that the authorities may very well increase their fees, so as to bring them more in line with other hospitals. The fees are lower than in any other place in the Territories, being 50 cents for general ward, 75 cents for semi-private ward and $1.50 for private. The other hospitals almost without exception charge $1.00 to $1.50 a day for public wards and $2.00 to $2.50 for private wards. There were 64 pauper patients treated here during the half year ending December 30, 1902."[182] The inspector's remarks implicitly suggest that if rates were higher, patients would be kept at bay, and consequently the number of available beds would be sufficient even if the population was growing. But, why did the Grey Nuns have lower fees? Since helping the poor was an integral component of the religious mission of the Grey Nuns, the sisters must have believed that higher fees would have been contrary to their mission; charging more might indeed have been detrimental to people of lower economic groups. In addition, having more favourable rates may have been considered a good administrative practice in a town where a municipal hospital created direct competition.

Sources of financial support

During this period of time sources of financial support varied in importance and regularity. The hospital was supported by donors, the *Ladies Aid Society*, the town

---

an independent entity and directly contributed to the lost of independent functions in the hospital. This topic is further addressed in the chapter devoted to the school of nursing.

[181] ASGME, EHH, Doc. 87A, Letter of G.A. Kennedy, hospital inspector of the North-West Territories to C.W. Peterson, deputy minister, 5 September 1901.

[182] ASGME, EHH, Doc. 91A, Report of G.A. Kennedy, 9 April 1903.

council, the territorial and federal governments, and by patients who paid hospitalization fees.

Gifts in kind

Gifts in kind constituted a non negligible source of support during the first years of operation.[183] The results presented in Table 1 show the value in dollars of gifts in kind between 1896-1900.[184] Interestingly, the amount for 1899 could not be determined as the records for that year were incomplete and unclear. No doubt the recorder had been affected by the events of the year.

TABLE 1

VALUE OF GIFTS IN KIND, 1896-1900

Year	Value
1896	$1000.17
1897	$464.61
1898	$350.75
1900	$248.00

Gifts in kind were classified into two large categories: food and nonedible products. Food products were the most commonly given items.[185] The Grey Nuns of St.Albert provided most of the food and although the Oblate priests did not give as much they were also regular donors. Each month a number of private enterprises and of local citizens contributed to the food stores. For example, in a typical month the Nuns of St. Albert gave $34.02 of food, the Oblates $9.80 and ladies from the town $4.90

---

[183] In 1896, the sisters received $1000.17 in gifts in kind and their operating income was recorded as $3466.50. ASGME, EGH, Livre de caisse and Visites canoniques.

[184] ASGME, Hôpital Général, Livre de caisse 1895-1939, dons en nature.

[185] This may explain why gifts in kind were no longer recorded after 1900. It may be suggested that as the hospital's income became more regular, and as the hospital's farming activities took more importance that the need to rely on others for food would have diminished.

(contributions of $0.40 to $1.50).[186]

Local citizens gifts usually came from women who donated homemade products such as bread, jam, preserves and cakes. Their donations as well as those of the Grey Nuns were linked with the rhythm of seasons. Vegetables came in the summer, preserves in late August, pumpkins in the autumn and turkey around Christmas. Food given by businessmen corresponded to their commercial activities. For example, in January 1896, Gariépy and Chénier's General Store gave ten bags of flour purchased at Ogilvie Mills and the same month Brakman-Ker Oatmill Co. gave two bags of oat flour. This company was located on the southside of the North Saskatchewan river which shows that the southsiders must also have appreciated and used the EGH. The Grey Nuns and the Oblates of St. Albert contributed livestock on at least two occasions. The Grey Nuns had already given a cow in 1895 and another one was added by the Oblates in 1896. A chicken and fifteen chicks were sent by the Grey Nuns in July of the same year.

In 1896, the EGH received the equivalent of $324.53 in nonedible products. Most of these goods were long lasting items. It is therefore not surprising that during the subsequent years this type of donation always comprised a marginal portion of the total donations.[187] Notably, the Oblate priests gave Church related items such as veils for the tabernacle and ceremonial clothing to be used by the chaplain. Some private citizens furnished hospital rooms by giving beds, mattresses and chairs and businessmen gave items from their stores. For example, Ross Bros. Hardware Store gave a washing machine and the Hudson's Bay Company donated barrels. These were probably used to store items such as lard and vegetables. Mayor McNamara and his wife gave two years of phone service and the physicians under the leadership of Dr. Roy gave an operating room table. Finally, the curate of St. Joachim's parish was particularly generous, his gifts including crystal bowls, an alarm clock, books and a cutter with fur blankets.[188]

---

[186] Ibid., November 1896.

[187] The only items of short duration were given by the Grey Nuns. Those were: candles, soap (159 pounds in 1896) and paper.

[188] ASGME, Hôpital Edmonton, Livre de caisse, 1896 and 1897.

Ladies Aid Society

The ladies' contribution could be specifically determined for only one year. In 1896, they organized two fund raising activities. In April 1896, "to surprise the sisters", the ladies organized a dance at which they collected $300.00. Unfortunately, Bishop Grandin discovered that this event had taken place and since the Church prohibited dancing, he ordered the Grey Nuns to refuse the profits made by this fund raising activity.[189] The ladies must have been disappointed but obviously they used their creativity and told the Superior not to worry because they would give the money to poor people of Edmonton. The chronicles recorded that by giving the money to poor people the initial goal was accomplished since most of the beneficiaries were regular users of the services provided at the EGH. Interestingly a very similar scenario occurred in 1915 at the Misericordia Hospital.[190] The sisters assisted by the physicians and nurses had organized a benefit concert at which dancing had taken place. Having heard of the event Bishop Legal took similar measures. However, that time the bishop confiscated the money and donated it to the Royal Alexandra Hospital.[191] The organizers must have been quite annoyed since the profits were given to their most important competitor. In the Fall of 1896 the ladies organized a benefit sale at which $552.00 was made, including $152.00 raised by the youth branch. This money was put to good use. The sisters bought $100.00 of coal, $100.00 of food and $300.00 of linen supplies such as blankets and pillows.[192]

---

[189] Although the Bishop could not interfere in the administration of the EGH, he could intervene in this case because dancing was considered a moral issue, an area in which the sisters had to comply with diocesan authorities.

[190] The Misericordia Hospital was operated by the Sisters of Miséricorde, another French Canadian religious order of Montreal. This hospital, established in 1900, was originally a maternity hospital whose mission was to complement the services offered at the EGH.

[191] John Gilpin, ***The Misericordia Hospital, 85 years of service in Edmonton***, (Edmonton: Misericordia Hospital, 1986), 61.

[192] ASGME, EHH, Doc. 25A.

Municipal support

Until the events of 1899, the city gave small grants towards the hospitalization of poor people from Edmonton. For example, in 1897, the town gave $338.45 to cover some of the costs incurred by the hospitalization of 57 poor residents of Edmonton.[193] However, in 1898, the town only gave $10.00. It may be suggested that giving little support may have been a tactic used by the town in order to try to gain control of the EGH. The data shows that city support was minimal and that the sisters could not count on municipal authorities as a regular source of support especially after the creation of the EPH.

Federal and territorial governments

The contribution of the federal government was limited. Federal support consisted of a 90 cents a day grant for immigrants who had been in Canada for less than twelve months. No support was provided for individuals who migrated from other parts of the country. Because of the bureaucratic process involved in having the hospital officially recognized, it took until 1898 to receive the first grant. On June 17, 1898 the hospital received $330.00 accounting for 371 days of treatments provided to immigrants in 1896/1897.[194] The territorial authorities gave partial coverage for all patients, but larger amounts were contributed for non-paying patients. Prior to 1898, the rates varied between 23 and 30 cents a day.[195] After 1898 a clear formula was established and the territorial government provided ten cents a day for every patient and an additional 40 cents a day for non-paying patients.[196] In addition, the territorial government paid its accounts more quickly than the federal authorities and this was of considerable assistance to the sisters. In February 1897 the EGH received a first grant of $574.45 covering the first six months of operation of the hospital.[197] Amounts of payments that were made between 1897 and 1904 could not be determined.

---

[193] Ibid.

[194] ASGME, EHH, Department of Interior, Ottawa, to Sister Letellier, Edmonton, 17 June 1898.

[195] ASGME, EHH, Doc. 25A.

[196] North-West Territories Legislature, "An ordinance to regulate hospitals", ***Consolidated Ordinances***, Chapter 20, Regina, 15 March 1899.

Patients' contribution

Data about patients' census and type of patients were not available. However, considering the hospitalization rates and the support provided by governments, patients who could afford to pay indirectly provided a greater part of the funds needed to operate the hospital and to provide care to poorer individuals. The maximum daily amount that could be received from governments was $1.00 a day for immigrants (90 cents from the federal and ten cents from the territorial legislature). In contrast a patient using a private room was charged $1.50 a day. The contribution of the government towards the hospitalization of that type of patient was only ten cents (from the territory). However, when hospitalizing patients who could afford private rooms, the hospital made 60 cents more a day than when hospitalizing immigrants. The benefit margin was even greater when comparing poor Canadians to private patients. In the case of poor individuals, the territory gave a total grant of 50 cents a day. In theory, the towns were also supposed to contribute. However, in practice there is no evidence that the EGH received significant support from Edmonton. This meant that in general a patient using a private room provided $1.10 more a day than a poor individual. The sisters regularly treated poor patients, but they also recognized the advantage of catering to rich individuals. The more they admitted rich individuals the more they could admit poorer ones.[198]

Hospital budget

Although details about income and expenses were not available for the period, the reports of the canonical visits included global figures as well as information about the hospital's assets and liabilities. The data shows that the sisters experienced great financial difficulties throughout the period. However, while in 1896 the canonical visitor had described the situation as "very worrisome", in 1904 the Superior General reported that she had found notable improvement.[199] In 1896, an income of $3,466.50 was recorded with expenses of $3,462.16, thus resulting in a surplus of $4.34. The same year assets were $113.84 and liabilities $26,224.21. Therefore the hospital had reimbursed less than $6,000.00 of the total $30,000.00 construction costs.[200] In contrast, in 1904 hospital income was $7,458.95, and expenses $5,708.40, thus resulting in a surplus of $1,750.25. Although the difference between liabilities and assets still meant that the hospital owed more then it possessed, the situation was significantly better as the debt had been reduced to $17,768.90.[201]

---

[197] ASGME, EHH, Doc. 32, Letter of Sister Marie-Xavier requesting funding to the Executive Committee of the North-West Territories of Regina, 7 July 1896; Doc. 35, Letter of Sr. Marie-Xavier to Mr. MacKinnon Lieutenant Governor confirming that she has received the government grant, 18 February 1897.

[198] The physical amenities of the hospital wing built in 1907 reflected the financial advantages associated with the hospitalization of richer individuals.

In conclusion, the period of 1895 to 1904 was characterized by a number of unexpected problems and can be seen as one of the most difficult in the life of the hospital. Although community support was strong especially during the first years of the institution, financial difficulties were unrelenting and the lack of municipal support certainly made it more difficult to administer the hospital. The crisis of 1899 exacerbated the situation resulting in the creation of the EPH which became the official municipal hospital and thus the beneficiary of concrete support from the city. Other levels of government were more consistent in providing financial assistance, but their support probably did not even cover the cost of hospitalizing a patient in a public ward. Yet, the sisters' commitment to charity and the competition created by the opening of the EPH made them maintain hospital rates at a minimum level so that less fortunate individuals would be able to continue to use their facility. The conflict of 1899 is a classic example of the power struggles occurring between women/men and nurses/physicians. Although the sisters had to bear the consequences of their actions they stood fast on their position as a matter of principle and continued to control admitting privileges. The few physicians who did not resign accepted the conditions set by the Grey Nuns. These physicians obviously shared similar values to those of the sisters and their attitude was probably linked to their religious and cultural backgrounds.

---

[199] ASGME, EGH, Visites Canoniques, 1896 and 1904, 7 & 16.

[200] Ibid., 1896, 7.

[201] Ibid., 1904, 16-17.

CHAPTER 7

A PERIOD OF GROWTH: 1905-1918

IMPROVEMENT OF FINANCES AND EXPANSION

From the birth of Alberta to the end of World War I (WWI), the EGH experienced a period of growth and of renewed hopes. This excerpt from the chronicles best summarizes the situation towards the end of the period: "Mais les épreuves ne durent pas toujours. Aujourd'hui, août 1916, vingt-et-un ans après l'ouverture de l'Hôpital, les Soeurs ont un bel établissement et une magnifique propriété. Elles jouissent aussi de l'estime de la population et de la considération du public. Dieu soit béni!"[202] Of importance, by 1916, the effect of the conflict which had led to the creation of the RAH was less perceptible. This municipal hospital still competed with the EGH, and the growth climate which had existed in Edmonton following the granting of provincial status to Alberta was temporarily halted by economic difficulties; nonetheless the Grey Nuns had been able to stabilize the financial status and position of the EGH in the city.

Overall, during the 1905-1918 era, Edmonton had high and low moments. In 1905, it became the capital city of the new province. Edmontonians having voted Liberal and thus helped the new government, reaped the benefits of power. However, general economic fluctuations combined with a local crash resulting from uncontrolled land speculation left many disillusioned about the "last best West".[203] At the provincial level creating a new structure kept the government well occupied. In terms of health care the liberal government decided to maintain the policies that had been adopted by the territorial government.[204] Importantly, provincial status brought the development of interest groups, notably the United Farmers of Alberta (UFA) and its women's branch the United Farm Women of Alberta (UFWA). The latter became a powerful lobby group which pressured the government to implement new health care measures, and of most major significance requested the vote for women.[205] In 1916, in the midst of WWI, women were granted this right at the provincial level and during the same session the first nursing legislation of Alberta was adopted.

---

[202] Quote translation: "But difficulties do not last forever. Today, in August 1916, twenty-one years after the opening of the Hospital, the Sisters have a beautiful building and a magnificent property. They are also valued and well thought of by the public. God be blessed! ASGME, EGH, Chroniques, 31 August 1916.

[203] Because the American western frontier was largely settled by the need of the 1890's, the Canadian Prairies became widely referred to as the "last best west" of North America. Palmer and Palmer, ***Alberta a new history***, 77; For more details about the American farmers' perception of Western Canada, see: Paul Sharp, "The American Farmer and the last best west", ***Agricultural History***, (April 1947), 65-75.

Administrative structure

Between 1905 and 1918, three superiors took their turns at directing the hospital. Although the administrative structure remained basically unchanged, the position of director of nursing was created in 1908. This new role was made necessary by the opening of the school of nursing. From then on the director of the school assumed a role in the administration of the hospital.[206]

Administrative issues

Three issues characterized this era: the need to expand, the need to open a school of nursing and, although less important, the hospital involvement in WWI. All of these issues were related to the financial status of the hospital. The major difference between this era and the previous one was that physicians kept a low profile. There is no evidence that they attempted to change the manner in which the sisters operated the institution.

The need to expand and to open a school of nursing

In 1904 with a population of 8,350, Edmonton's incorporation status moved from town to city. During subsequent years, hundreds of newcomers settled in the area. The yearly rate of population increase was phenomenal and reached its peak in 1912, when, within twelve months Edmonton's population rose from 31,000 to 50,000.[207] The growth continued and by 1914 72,516 people lived in the city.[208] However two years later, the number of citizens had almost dropped to the level of 1914: 53,846 individuals. The fluctuations in Edmonton's population can be traced to many factors. Political life was unquestionably an important factor which led to the rapid development of Edmonton. Having voted Liberal at both provincial and federal elections, Edmontonians had representation in both governments. In contrast, as a result of their voting patterns Calgarians were primarily represented by members of the opposition. Consequently, Edmonton became the capital of the province, new railway lines between Edmonton and northern areas were constructed, and the University of Alberta was established in the town of Strathcona.[209] The role of Edmonton as the gateway to the north contributed to its prosperity. Significantly, during the first years of this period, the rural areas that relied on the city as a wholesale and service centre were blessed by good wheat prices.[210] An important effect of the boom was that land and real estate speculation became common in the early years of the 1910's decade. Unfortunately on the eve of WWI wheat prices began to decrease and the completion of railroad construction programs created unemployment.[211] In 1913, sensing the change in the state of the economy, speculators panicked and the real estate market evaporated.[212] Edmonton had grown too quickly and the new economic problems of its citizens meant that taxes remained unpaid and that little money was available to pay for the developments in infrastructure that had been undertaken. "By February 1914, there were 4,000 unemployed in a city of 72,000, straining civic relief facilities and contributing to labour unrest and strife."[213]

---

[204] Kenneth Brown, "The evolution of hospital funding in Alberta," (Health Services Administration major paper, University of Alberta, 1983), 31.

[205] Health care policies are addressed in the chapter devoted to patient care delivery.

[206] Details are provided in the chapter about the school of nursing.

---

[207] MacGregor, ***Edmonton, A history***, 153-189.

[208] ECA, population statistics, city census of 1914.

[209] Strathcona amalgamated with Edmonton in 1910.

[210] MacGregor, ***Edmonton, A history***, 139-208; Palmer and Palmer, ***Alberta a new history***, 137-150.

[211] Palmer and Palmer, Ibid., 106

[212] ASGME, EGH, Chroniques, 1913.

It is evident that between 1905 and 1914, the rapid growth of Edmonton created a need for more hospital beds. In order to expand, all four hospitals in Edmonton adopted the same strategy; namely, to open a hospital school of nursing. The RAH and the new University of Alberta Hospital (UAH) led the movement admitting their first students in 1905. The two Roman Catholic hospitals continued to depend on their advantage of a religious nursing workforce. However, it was soon recognized that the number of available sisters was insufficient to meet the demand. Thus, the Misericordia Hospital (MIS) and the EGH chose to establish schools of nursing in 1907 and 1908 respectively.[214] Maintaining nursing schools had become an important tool in the increasingly competitive world of hospital care because the presence of an army of students meant that more care could be given. In 1908, if the EGH had elected not to open a school, prospective nursing students would have gone to the schools of the other three hospitals. It can be suggested that lacking a student workforce, the EGH would have fallen behind in the competitive world of hospital care, since without the labour provided by students it would have been difficult if not impossible to plan expansion of facilities.

Because the growth of Edmonton was associated with favourable economic conditions the accumulation of wealth permitted affluent citizens to seek hospital care when they became ill. In order to receive special services such as private rooms or private nursing care, these people agreed to pay more than other users. Being able to count on the additional income provided by wealthy clients was in fact vital to many institutions. The greater sums generated by the hospitalization of these individuals could be used to cover the cost of providing services to less fortunate persons. All types of hospitals realized the benefits of such system. However, it was of primary importance for the sisters, since it permitted them to fulfil a key aspect of their religious mandate which was to provide free services to the poor.

---

[213] Palmer and Palmer, ***Alberta a new history***, 166.

[214] Tony Cashman, ***Heritage of service, the history of nursing in Alberta***, (Edmonton: Alberta Association of Registered Nurses, 1966).

Thus in 1907, in light of these factors, the Grey Nuns decided to add a four storey wing to the EGH. The design of the patient care areas confirms that the sisters wished to attract richer patients. Two surgical rooms were added and at least 22 out of the 26 patients' rooms that were added were private and semi-private facilities.[215] Four years later two floors were added to the original building and in 1913 construction of another three storey building began.[216] It was completed in 1916 and included a medical ward that could accommodate 26 patients.[217]

In light of the economic difficulties which arose in Edmonton in 1913, it may seem curious that the sisters decided to undertake the construction of another wing just at that moment. Reasons justifying this decision were provided in the chronicles in which it is stated that when the "real estate crash" occurred, construction materials had already been purchased and that the space was necessary to house the increasing number of nursing students.[218] Further, it was noted that without this extension the EGH would not have been able to compete with the other hospitals of the city.

World War I

Albertans readily answered the call to participate in the war effort. Between 1914 and 1918, 45,136 Albertans served overseas. Of this number, 6,140 never returned. Patriotism was strong in the province and was reinforced by supportive views held by immigrants from the United Kingdom and France who were willing to take the uniform to defend their mother country as well as their adopted land. Another important factor pushing men to enrol was the high unemployment rate that existed following the economic collapse of 1913.[219] That factor was identified in the EGH chronicles: "The war has paralysed the business and industrial activities of the city. Young men have the choice to starve or get enrolled."[220]

---

[215] There were 10 private and 12 semi-private rooms. The number of beds in the remaining four rooms could not be determined. ASGME, EGH, Chroniques, 1907.

[216] Ibid., 1911 and 1913.

[217] It was impossible to determine other services offered in that wing. Ibid., 1916.

[218] Ibid., 1913 and 1916.

In November 1915, the federal government asked the sisters if they would be willing to hospitalize soldiers. The sisters agreed because they believed it was important to assist the soldiers and in view of their need for the additional income.[221] Until September 1916, the EGH received soldiers who had not yet gone to war, while after that date and until the end of the conflict, services were rendered to returning soldiers. Exact data about the number of soldiers who were hospitalized were not available. However, it is known that in 1915 the hospital admitted at least 108 soldiers, and that 170 were hospitalized in the winter of 1916.[222]

Sources of financial support

Gifts in kind and citizen's donations

Gifts in kind were not recorded between 1899 and 1912. It is likely that the number of such gifts decreased after the opening of a second hospital in Edmonton. In addition, as the sisters became more self-sufficient, food hampers which had constituted the majority of the gifts would not have been needed as much. However, gifts in kind must not have entirely disappeared since the annual reports of 1913-1914 and 1915-1916 included that the equivalent of $500.00 and $434.00 respectively had been received in that form. After 1916 the annual reports included only the total amount of money that was received from donors. Results presented in Table 2 provide the amounts received between 1913 and 1919.

---

[219] Palmer and Palmer, ***Alberta a new history***, 167-169.

[220] ASGME, EGH, Chroniques, November 1915.

[221] Ibid.

[222] ASGME, EGH, Chroniques, November 1915 and August 1916.

TABLE 2
VALUE OF GIFTS RECEIVED DURING THE 1910'S[223]

Year	Amount
1913-1914	$925.05 *
1915-1916	$630.60 *
1916-1917	$419.50
1917-1918	$1142.85
1918-1919	$952.00

* includes gift in kind

The value of Christmas gifts was recorded in the *Livre de caisse* for a number of years between 1909 and 1915 (See Table 3). Comparing the results presented in Tables 2 and 3 for the years of 1913 and 1915, it appears that during these years, 44.43% and 37.42% of the gifts were received around Christmas time. These results are not surprising since people tend to be more generous at that time of the year. Christmas gifts came from local businesses and private individuals. Businessmen either gave money or items from their stores. For example, in 1909 the Edmonton Wine and Spirit Co. gave liqueurs. Gallagher Hull Co., a meat market, donated a turkey and a rooster. Larue and Picard General Store, Révillon Frères and the Royal Fruit Co. chose to give money.[224] The French Révillon brothers always made the most substantial gift received by the sisters. They donated $100.00 every year until 1913 with a final gift of $5.00 in 1914. It is likely that their company was affected by the economic crash of 1913 and by the war, since fur was a luxury item for which the demand probably decreased during these years of hardship.

---

[223] ASGME, EGH, Annual reports; Data not available for 1914-1915.

[224] ASGME, EGH, Livre de caisse, 1909; Révillon Frères were international fur merchants. The nature of their enterprise as well as that of Gallagher Hull Co. was identified in J.A. MacGregor, ***Edmonton a History***, 115 and Hart, ***Ambitions et réalités***, 65.

TABLE 3

CHRISTMAS GIFTS 1909 TO 1915[225]

Year	In nature	Money	Total
1909	$79.00	$134.00	$213.00
1910	$140.00 -	$110.00 +	$250.00
1911	$283.00 -	$100.00 +	$383.00
1913	$111.00	$300.00	$411.00
1914	?	?	$209.50
1915	?	?	$236.00

At first glance, results in Table 3 seem to show that the value of Christmas gifts reflected the economic climate. The value of donations increased until 1913 and dramatically decreased in 1914. However, if Révillon Frères' contribution is excluded, it is apparent that Edmonton's citizens were very generous during the war years and that in fact they gave more then than during the prosperous years of 1909 and 1910.[226] It must be noted that the Catholic West End Parish of the Women's Catholic League gave substantial amounts throughout the entire period.[227]

Gifts in kind usually consisted of chocolate, oranges and candies. It is interesting that Drs Wilson and Braithwaite, who had both left the EGH during the 1899 conflict, each made small donations in 1909. It could not be determined if they had regained some admitting privileges at the EGH but their Christmas gifts show that the level of animosity over their earlier conflict with the sisters must have been decreased by then.

---

[225] ASGME, Hôpital Edmonton, Livre de caisse 1895-1939, dons en nature; No available data for 1912.

[226] Excluding the Révillon Frères the sisters received $113.00 in 1909, $150.00 in 1910, $204.50 in 1914, and $236.00 in 1915.

[227] Their donations ranged between $35.00 and $50.00. ASGME, EGH, Livre de caisse 1909 to 1915.

That healing of old wounds was taking place was also revealed by the $5.00 donation made by the Ladies of the Methodist Church in 1915.[228] The construction of the 1907 wing also stimulated citizen's generosity. A number of individuals, groups and businesses donated money towards the purchase of furniture. Twelve out of the twenty-six new patient rooms were furnished by donors.[229]

Ladies Aid Society

For unknown reasons, the participation of the ladies started to decrease during the early 1900's, and by 1906 the group was disbanded.[230] The creation of the EPH (RAH) may have split the group. However, based on the list of original members, it is apparent that many ladies must have been Catholic.[231] Therefore, the opening of the EPH cannot be considered as the only reason for the disbandment of the Society. In addition, the opening of the EPH may have made Catholic women even more militant. Although it could not be verified, it is suggested that the decline of the Society might have been related to the creation of other Catholic women's associations.

Municipal support

The city contribution remained a marginal part of the global budgets of that period of time (less than 10%). However, in November 1915, the hospital lawyer (Mr. Giroux) convinced the city council to exempt the sisters from paying property taxes on their empty lots. This constituted a substantial gain for the sisters since it meant that the hospital would saved up to $2,000.00 a year.[232]

---

[228] Ibid.

[229] Four rooms were furnished by local citizens, three by physicians, one by the Oblate priests, one by the Bank of Hochelaga, one by Standard R & H Company and one by Otis elevators. ASGME, EGH, Chroniques, 1907.

[230] Ibid., 1906.

[231] Many were French Canadian Catholics, and others had Irish sounding names which would also make it very likely that they were members of the Catholic Church.

[232] ASGME, EGH, Chroniques, November 1915.

Provincial and federal support

There is no evidence that provincial and federal funding rates were better than in the previous era. However, the hospitalization of soldiers during WWI increased federal participation. In 1916, the defence department gave $1.15 a day for soldiers using public wards, $1.50 for semi-privates and $2.00 for private rooms. An additional $2.50 a day was given if the soldier required the services of a private nurse. The income resulting from the hospitalization of soldiers could not be determined since admission levels and length of stay could not be established. However, it is known that at least 256 soldiers were admitted in 1915-1916 and that by July 1917 there were still many serviceman at the hospital.[233] There was some indication that the government contract was profitable for the EGH. In 1916, the income resulting from the hospitalization of soldiers was sufficient to pay down all interest due on the loan for that year and some of the capital on the same loan, and to make some renovations in the operating room and the sisters' refectory.[234] Thus, the governmental contract must have been seen a significant supplement to the hospital budgets.

Hospital budgets

Between 1913 and 1936, the annual reports submitted by the EGH to the Motherhouse included detailed hospital budgets. These reports provided information about income/expenses, assets/liabilities, and details such as the number of admissions and the number of laboratory procedures. The results presented in Table 4 give information about the operating budgets of 1913-1914, 1916-1917 and 1918-1919. The data show that during each of these fiscal years the sisters managed to accumulate small operating surpluses. Results presented in Table 5 indicate that the accumulated debt also decreased during this period of time. Globally the situation was rather favourable.

---

[233] Ibid., 1915 to 1917.

[234] Ibid., December 1916.

TABLE 4

OPERATING BUDGETS OF
1913-1914, 1916-1917 and 1918-1919

	1913-1914	1916-1917	1918-1919
Income	$56,740.77	$54,559.10	$103,555.70
Expenses	$55,332.06	$50,601.76	$97,217.92
Surplus	$1,408.71	$3,957.34	$6,337.78

TABLE 5

ASSETS AND LIABILITIES IN
1914, 1917, and 1919

	1914	1917	1919
ASSETS			
Building & land	$400,000.00	$400,000.00	$400,000.00
Supplies	$600.00	$55,037.00	$55,800.00
Other	$1,408.71	$8,402.57	$160.83
TOTAL	$402,008.71	$436,439.57	$455,960.83
LIABILITIES			
To Motherhouse	$10,000.00	$1,740.69	---
To others	$84,015.00	$63,900.00	$40,200.00
TOTAL	$94,015.00	$65,640.69	$40,200.00
NET SURPLUS	$307,993.71	$370,798.99	$415,760.83

Data presented in Table 6 show that at the end of the 1916-1917 and 1918-1919 fiscal years, the hospital debt was distributed among three creditors[235] which were two

---

[235] The 1917 debt to the Motherhouse was of a different nature. The amount was the indemnity due to Montreal. Each house of a religious order must pay a per capita tax to its motherhouse. The money thus accumulated was used to finance administrative operations necessary to offer services to member houses.

Grey Nuns institutions (Holy Cross Hospital and Youville convent), two Oblate priests' institutions (the parish of St. Albert and the Sacred Heart Hospital[236]) and the Edmonton Crédit Foncier which was managed by French Canadians.[237]

TABLE 6

CREDITORS IN 1917 AND 1919

CREDITORS	1917 Amount (Rate)	1918 Amount (Rate)
Crédit Foncier of Edmonton	$27,500.00 (6%)	
Holy Cross Hospital of Calgary	$25,000.00 (4%)	
Sacred Heart Hospital of Fort Providence	$11,400.00 (4%)	$11,400.00 (4%)
Motherhouse of Montreal	$1,740.69 (?)	
Catholic Parish of St. Albert		$3,800.00 (5%)
Youville Convent of St. Albert		$25,000.00 (5%)
TOTAL	$65,640.69	$40,200.00

The administrative abilities of the sisters in the area of financial management are best demonstrated by considering the source of the EGH accumulated debt. By 1916, two wings had been added to the 1895 hospital site. Construction costs for the 1907 wing were $113,918.96 and the section built between 1913 and 1916 required $75,400.00. Therefore, the sisters had to find $189,318.96 to cover total construction costs. Considering that in 1917 they owed $65,640.69, it is apparent that they had already erased the debt incurred for the 1907 wing. Undoubtedly, the favourable economic climate of 1907 to 1912 facilitated the redemption of that debt. However, the administrative talent of the two superiors of the era should not be underestimated. Sister O'Brien had asserted that adding a new wing consisting of a large number of private rooms would ensure financial stability. It is obvious that for that period of time her predictions were accurate. It is also apparent that her successor, Sister Bissonnette who administered the EGH from 1908 until 1916, was equally talented. On the eve of her transfer to another institution it was stated in the chronicles: "Sister Bissonnette was above all a business woman who neglected nothing to keep the house in good order. She did all accounting and supervised admissions and discharges. When she came to this hospital, the debt was $108,000.00 and now it is of $88,000.00."[238]

---

[236] Grey Nuns worked at that hospital.

[237] Hart, ***Ambitions et réalités***, 89.

The results presented in Tables 7 and 8 provide details about the income and expenses for the years of 1913-1914, 1916-1917 and 1918-1919. It is readily apparent that a very large portion of the income came directly from the patients who used the hospital. In 1913-1914 their contribution comprised 53.88% of hospital income while it accounted for almost 70% in 1916-1917 and 1918-1919. Taken at face value, the patient contribution increased by almost 20% between 1914 and 1917. However, $13,000.00 had been borrowed in 1913-1914 and if this amount is deducted from the total income and adjusted percentages are established (based on an income of $43,740.77) the patients' contribution reaches 69.89%. Thus it may be suggested that patient contributions to hospital operations remained stable during that period of time. If all other figures are adjusted in the same manner, it becomes apparent that the percentage comprised by each source of income did not significantly vary.

It is must be noted that the amounts labelled "nursing" income comprised only payments for services rendered outside the hospital. Most of these services were rendered by student nurses, and although the amounts were small, they indicate that students brought additional revenues to the hospital.

---

[238] Free translation. ASGME, EGH, Chroniques, August 1916.

TABLE 7

INCOME IN
1913-1914, 1916-1917 AND 1918-1919

SOURCE	1913-1914 Amount (%)	1916-1917 Amount (%)	1918-1919 Amount (%)
Borrowed	$13,000.00 (22.91)	---	$7,300.00 (7.05)
City	$2,381.75 (4.20)	$4,475.30 (8.20)	$6,647.65 (6.42)
Farm	---	$680.00 (1.25)	$1,530.10 (1.47)
Governments	$7,502.65 (13.22)	$8,156.75 (14.95)	$9,359.25 (9.04)
Nursing	$894.00 (1.57)	$215.00 (0.39)	$1,850.00 (1.79)
Patients	$30,571.32 (53.88)	$38,080.65 (69.80)	$69,745.80 (67.35)
Other	$2,391.05 (4.21)	$2,951.40 (5.41)	$7,122.90 (6.88)
TOTAL	$56,740.77 (100.00)	$54,559.10 (100.00)	$103,555.70 (100.00)

Results presented in Table 8 show that construction/renovations costs, reimbursement of loan and interest (including the amount paid to the Motherhouse in 1918-1919) and purchase of food constituted the largest expenses of the hospital. It is evident that food purchase was the largest expense in terms of spending directly related to the day-to-day functioning of the hospital. It is reasonable to suggest that if the hospital had not been located in a city, farming operations would have been much more considerable. The fact remains that although operated on a small scale farming by the sisters was a profitable enterprise as noted in the data presented in Tables 7 and 8. The budgets showed that salaries comprised less than 10% of hospital expenses. This small proportion should be seen as usual for a hospital of that era since most institutions relied on a low paid workforce comprised of many nursing students. Considering that the number of hospital beds at least tripled with a concomitant rise the hospital budget not quite double during that era, the advantage derived from operating a nursing school is clearly evident.

TABLE 8

EXPENSES IN 1913-1914, 1916-1917 AND 1918-1919

EXPENSES	1913-1914		1916-1917		1918-1919	
	Amount	(%)	Amount	(%)	Amount	(%)
Cons./renov.	$22,740.29	(41.10)	$1,043.94	(2.06)	$4,282.35	(4.40)
Farm	$72.74	(0.13)	$208.07	(0.41)	$273.45	(0.28)
Food	$10,394.41	(18.78)	$15,606.14	(30.84)	$20,178.39	(20.75)
Insurances	$4,119.36	(7.44)	$240.00	(0.47)	$899.00	(0.92)
Interests	$4,559.29	(8.24)	$3,523.00	(6.96)	$2,996.22	(3.08)
Legal fees	----		$111.00	(0.22)	$380.00	(0.39)
Loan reimbursed	----		$12,500.00	(24.70)	$22,000.00	(22.63)
Motherhouse	----		$240.00	(0.47)	$13,807.00	(14.20)
Salaries	$4,569.30	(8.26)	$3,591.35	(7.10)	$7,444.30	(7.66)
Supplies	$5,008.32	(9.05)	$7,283.54	(14.39)	$15,991.08	(16.45)
Taxes	----		$1,344.21	(2.66)	$1,150.42	(1.18)
Utilities	$3,704.12	(6.69)	$4,406.81	(8.71)	$7,068.36	(7.27)
Other	$164.24	(0.30)	$503.70	(1.00)	$747.35	(0.77)
TOTAL	$55,332.06	(100.00)	$50,601.76	(100.00)	$97,217.92	(100.00)

Farm includes: garden equipment, animals and food for animals. Supplies include: clothes and linen, clothes washing, instruments, merchandise, operating room and lab supplies, paper, and pharmaceutical products. Utilities include: heat, light, phone, travel.

In conclusion, the 1905-1918 era may be considered a prosperous one for the hospital. In response to the growth of Edmonton, the sisters added new beds to the EGH and the corresponding need for more caregivers was satisfied by the creation of a school of nursing. Significantly, additional hospital wings which were built in the era included a large number of private and semi-private rooms. It is clear that the sisters realized that the financial situation of the EGH could be improved by the additional income that could be gleaned from patients using these facilities. The hospitalization of soldiers also contributed to the stabilization of the hospital's financial status. By the end of 1918, the financial condition was much improved in comparison to that of 1904. The debt had been reduced and the property had risen in value. It is not surprising that the sisters came to the conclusion that once again it was necessary to increase the number of beds in the hospital.

CHAPTER 8

ADAPTING TO THE ENVIRONMENT: 1919-1938
STANDARDIZATION AND ECONOMIC PRESSURES

As in previous years, the hospital was affected by internal and external pressures. However, external pressures became particularly strong between 1919 and 1938. From an administrative standpoint, the hospital standardization movement and the impact of the 1930's economic depression were two major forces. Importantly, both forces affected the entire continent. The search for common minimal standards was a positive development for the hospital world and the Grey Nuns readily participated in associations which supported the implementation of reforms. In contrast, the economic depression shook the very foundations of the hospital and drastically affected its operations. The shock altered patient care services which in turn affected the school of nursing and pushed the sisters to create a lay advisory board.

Administrative structure

The administrative structure of the hospital remained relatively unchanged, however, and the six Superiors of the era retained all final decision-making power. However, in the early 1930's, medical services were organized into a more formal structure and the position of medical director was established. In addition, a number of medical committees were formed.[239] These developments were linked to the implementation of the standards set by the American College of Surgeons. The creation of a lay advisory board also occurred in the 1930's and represented an innovative method for the sisters to gain advice from the members of this board who were prominent members of the community engaged in various business and professional activities. It is clear that this board was advisory in nature and that the sisters did not let go of their authority. However, the depression years brought a positive development: the creation of the Edmonton Group Hospitalization Plan.

Administrative issues

Construction plan

In 1918, the sisters came to the conclusion that new beds were once again needed at the EGH. Requesting permission to expand the local superior wrote: "Patients are always numerous and I was told that today we had to refuse the convenience of a private room for ten patients who had requested it. Private rooms are usually all taken by farmers who tend to be very rich around here."[240] Permission to build was granted and construction began in the Spring of 1920.[241] The new wings (south and west of original building) included new laboratories, the first radiology department of the hospital, new quarters for nursing students and a maternity ward. The maternity unit had private, semi-private and public rooms. Significantly, the public rooms included only three beds. This innovation was believed to be advantageous in facilitating work and increasing patient comfort and privacy.[242] The expansion had obviously been needed since the rooms were well utilised as soon as they were opened.[243]

---

[239] By 1937, medical staff committees included: laboratory, library, medical, nursing school, obstetrical, records and interns, and surgical. ASGME, EGH, Chroniques, 1937.

Hospital standardization movement

Background

One of the most important issues in the North American hospital world of the late 1910's and 1920's was the consensus that developed around the concept of hospital standardization. The emergence of the movement came as a side effect of the 1910 Flexner Report and was lead by two major players: the American College of Surgeons (ACS) and the Catholic Hospital Association of the United States and Canada (CHA). Although the positions taken by these two associations were clearly in response to Flexner's recommendations, it must be understood that the rising social consciousness of North America had provided the impetus for change.

The advent of industrialization had greatly transformed eastern North America and between 1890 and 1920, urban middle-class populations gained awareness of the increase in threats to public health. Importantly, the thousands who had left rural areas to find work in the factories had not found the promised prosperity. The exploitation of children and women was common, families were poor and underfed, and living in the shadow of chimneys brought disease and social unrest.[244]

---

[240] ASGME, EHH, Doc. 100A, Letter of local superior to Mother Piché, 11 March 1918.

[241] ASGME, EGH, Chroniques, May 1920.

[242] Ibid., and January 1921.

[243] The additional beds brought the total number to 200.

Even if it is reasonable to suggest that many members of the middle-class who began to recognize the misery of industrial neighbourhoods originally had self-serving motives in that they realized the potential danger of increasing poverty on their own families, the fact remains that the lobby movements they created pushed governments to intervene. On both sides of the 49th parallel, reforms began to take shape primarily because of urban problems, but the new awareness rapidly spread to rural and developing parts of the continent. Boards of health became more common, public health services gained an infrastructure and hospitals appeared at a faster rate. In this time of progress, discoveries and technological advances were numerous and the population was increasingly vocal about demanding the best care possible.

Canadians and Americans experienced similar problems and in many cases interest groups took the form of cross-national associations. This type of collaboration was particularly strong in the health care field. For example, the first nursing and hospital associations ignored the political frontier. In fact, the permeability of the border to population movements facilitated the exchange of ideas. Significantly, many North American universities attracted students and academic personnel from both countries. Political ideologies also crossed the border. For example, the agrarian movement of Canadian prairie provinces borrowed many concepts from similar interest groups found in neighbouring American states.[245]

---

[244] For more information about the effect of industrialization in urban Canada see: Herbert Brown Ames, ***The city below the hill: a sociological study of a portion of the city of Montreal***, (Montreal: Imprimerie Bishop, 1897); Terry Copp, ***Classe ouvrière et pauvreté. Les conditions de vie des travailleurs montréalais, 1879-1929***, (Montréal: Boréal Express, 1978).

[245] Although not recent both references are still widely used. P.L. Sharp, ***The agrarian revolt in Western Canada: a survey showing American parallels***, (Minneapolis:

Therefore, it is not surprising that when Abraham Flexner conducted his survey of medical education in the United States, he also included the Canadian medical schools in his sample. Published in 1910, the report demonstrated that medical education lacked standards and that urgent reforms were needed.[246] The report gained much support from educational institutions. However, reforms could not be implemented without the collaboration of hospitals, and the American College of Surgeons attempted to implement change. Unfortunately, the College found a great deal of opposition from hospital administrators and general practitioners. "... most communities [towns] simply refused to believe that the conditions against which the College of Surgeons inveighed were to be found in their hospitals."[247] By 1915, it had become evident to the College that the establishment of better standards would not take place unless support and assistance were secured. The College did find an ally in the newly created Catholic Hospital Association.

The Catholic Hospital Association (CHA)

After the publication of the Flexner Report, Catholic religious orders realized that the proposed changes to medical education would affect the functioning of their hospitals. Similarly, Catholic medical school authorities were concerned about the future of their institutions. In July 1914, the Sisters of St. Joseph of Carondelet of St. Paul, Minnesota met with Father Charles Moulinier, regent of the Marquette University School of Medicine. Father Moulinier had been asked to conduct the sisters' annual retreat. Knowing that he was well versed in the field of medical education, the sisters decided to share with him the problems which were encountered in all hospitals of the Order. Discussing the issues, Father Moulinier suggested that the creation of a Catholic Hospital

---

University of Minnesota Press, 1948); W.L. Morton, ***The progressive party in Canada***, (Toronto: University of Toronto Press, 1950).

[246] Philip A. Kalish and Beatrice J. Kalish, ***The advance of American nursing***, 2d ed., (Toronto: Little, Brown and Company, 1986), 297.

[247] Robert J. Shanahan, S.J. ***The history of the Catholic Hospital Association, 1915-1965, fifty years of progress***, (St. Louis: The Catholic Hospital Associations of the United States and Canada: 1965), 2.

Association might be useful. He suggested that through this association, Catholic hospitals would be able to address timely questions and adopt common solutions. Within less than a year after this retreat, an association had been established: "The object and purpose of this Association shall be the promotion and realization of progressively higher ideals in the religion, moral, medical, nursing, educational, social and all other phases of hospital and nursing endeavour and other consistent purposes especially relating to the Catholic hospitals and schools of nursing of the United States and Canada."[248] By 1916, six Canadian provinces were members of the association. The early support of the bishops from both countries and the international nature of faith contributed to the immediate involvement of Canadian hospitals.[249]

The Catholic Hospital Association and the American College of Surgeons

Since the American College of Surgeons (ACS) had been looking for allies, and realizing that the CHA was supportive of its position, the ACS decided to seek its assistance. The CHA agreed to participate in the standardization movement and played an instrumental role in implementing the plans of the ACS.[250] It is important to recall that more than 50% of all beds in North America were found in Catholic hospitals, many of which were among the oldest institutions of the continent.[251] Many physicians were opposed to the ACS position and the power they had in non-Catholic hospitals had thus far led to the non-participation of many of these institutions. In contrast, physicians did not have equivalent decision-making abilities in Catholic hospitals and consequently the

---

[248] Ibid., 21, cited from Article II of the Catholic Hospital Association Constitution.

[249] André Cellard and Gérald Pelletier, ***L'histoire de l'Association Catholique Canadienne de la Santé, Fidèles à une mission***, (Ottawa: l'Association Catholique Canadienne de la Santé, 1990), 13.

[250] Harvey G. Agnew, ***Canadian hospitals, 1920 to 1970 - A dramatic half century***, (Toronto: University of Toronto Press, 1974) 37; Cellard and Pelletier, ***L'histoire de l'Association Catholique***, 52.

[251] Shanahan, ***The history of the Catholic Hospital Association***, 26.

ACS was able *via* the CHA to implement its accreditation program.[252] However, competition was such that non-catholic hospitals did not resist very long. They simply could not afford to fall behind Catholic hospitals. Thus, the massive support given to the ACS by the member hospitals of the CHA resulted in a defeat of forces opposing the implementation of its recommendations.

Much of the success of the accreditation movement has been attributed to the standardization crusade orchestrated by Father Moulinier. Between 1918 and 1923 he visited all Catholic hospitals of North America, explained the plan and gave advice about the implementation of reforms necessary to obtain accreditation. Father Moulinier, accompanied by Dr. L. Bowan, Director of the ACS, visited Edmonton in 1919: "The main focus of their talks was to convey the need to re-organize each hospital for the better comfort and well-being of patients. They insisted on the formation of a medical committee, an administrative office, the preparation and conservation of the medical history of each patient, as well as the reports of the medical staff, and laboratory examinations if the Sisters wished to obtain good results in their hospital organization and management."[253]

Grey Nuns' participation

The Grey Nuns were active members of the CHA and were found at all levels of the organization. In 1921, a Western Canada Conference was organized and Mother V. Allaire, Provincial Superior of the Grey Nuns of St. Boniface at the time, was elected President.[254] This conference lasted until 1924 when it disbanded for reasons which are obscure. However, in 1932 Sr. Mann, a Grey Nun from St. Boniface, proposed the creation of a Prairie conference. Her plan was approved and the first meeting was held at Winnipeg in May of the same year; the superior of the EGH, Mother Laberge, became the first president of the group.[255] Significantly, Mother Allaire was by then on the executive committee of the large cross-national association, and she specifically promoted the creation of Canadian provincial conferences.[256]

---

[252] Agnew, ***Canadian hospitals***, 37.

[253] Thérèse Castonguay, SGM, ***A mission of caring. Catholic Health Association of Alberta, a chronicle of the first fifty years***, (Edmonton, the Catholic Health Association of Alberta, 1991), 2.

[254] Cellard and Pelletier, ***L'histoire de l'Association Catholique***, 15.

Alberta and the EGH

The Grey Nuns of Alberta were particularly involved in the local conference and in the provincial association (the Catholic Health Association of Alberta [CHAA], which was created in 1943 was known as the Catholic Hospital Association of Alberta until 1966). Importantly, of the 21 presidents who served the CHAA between 1943 and 1970, five were Grey Nuns and two were medical directors of Grey Nuns' hospitals.[257] The EGH almost always sent delegates to large cross-national meetings.[258]

The 1919 visit of Father Moulinier gave impetus to the standardization movement at the EGH. However, the chronicles revealed that the sisters were already moving ahead with reforms. For example, in 1917, the sisters held a meeting to discuss the standardization of nursing care and of other hospital services.[259] In addition, the movement towards hospital accreditation was generally strong in Alberta. In particular, the Alberta Hospital Association (AHA), created in 1919, had as one of its initial objectives the facilitation of hospital standardization.[260] In 1920, the physicians of the EGH organized a medical committee and also began to formally meet with colleagues in other hospitals.[261] It is evident that the EGH and all other Edmonton hospitals took the necessary steps towards accreditation since they were all officially recognized by the ACS in 1923. The same year, the Holy Cross Hospital (Calgary), the Calgary General and the Medicine Hat General were also granted accreditation.[262]

---

[255] Ibid., 20; ASGME, EGH, Chroniques, May 1932.

[256] Cellard and Pelletier, ***L'histoire de l'Association Catholique***, 8; Mother Allaire served on that executive from 1929 until 1939.

[257] Two Grey Nuns were president while they worked at the EGH: Sr. Florence Keegan 1949-1950, and Sr. Bernadette Bézaire 1954-1956. Dr. Rupert Clare, medical director of the EGH occupied the position in 1969-1970. In addition, the other Grey Nuns who served as president all worked at the EGH prior to or after their presidential mandate. Castonguay, Ibid., 185-186.

[258] ASGME, EGH, Chroniques, 1921 to 1970.

[259] ASGME, EGH, Chroniques, 1 July 1917.

[260] Agnew, ***Canadian hospitals***, 80.

The granting of accreditation in 1923 should not be interpreted as the end of physicians' reluctance towards the accreditation movement. The physicians of the EGH established a medical committee in 1920 and although the minutes of their meetings were not kept until 1933, some information about their activities was recorded in the chronicles. This data revealed that poor charting by physicians was a constant problem. It was found that the President of the physicians' committee and the Superior frequently urged the medical staff to improve charting of case histories, progress notes and operating room records.[263] Physicians' resistance in these areas suggests that some may have been opposed to standardization or at least to change. The poor participation of physicians is best indicated by data about the accreditation report of 1927. That year, the inspector of the College of Surgeons informed the superior of the EGH that physicians' meetings were not sufficiently elaborate, that their charting was incomplete especially in respect of operating room notes, and that the hospital needed to secure the services of an orthopaedic surgeon.[264] Concerning this state of affairs the chronicles stated: "Ces remarques sont très justes; mais la question est assez difficile à régler à cause de l'esprit d'antagonisme de notre corps médical et de l'apathie d'un grand nombre quand il s'agit d'améliorer leur manière de faire."[265] The physicians were informed of the report and accepted the need to comply with the recommendations related to meetings and charting. However, "after much debate" they refused to welcome an orthopaedic surgeon among their ranks.[266] The refusal to comply with this request indicates that the physicians had considerable power and that they obviously had control over the "hiring" of new specialists.[267]

---

[261] ASGME, EGH, Chroniques, 1920 and 1921.

[262] ASGME, EHH, Doc. 108, Letter of the American College of Surgeons to the Superior of the EGH, Chicago, 23 October 1923.

[263] ASGME, EGH, Chroniques, 1921, 1922, 1923 and 1926.

[264] Ibid., 8 April 1927.

[265] Ibid.; quote translation: "These comments are accurate; but these issues are difficult to solve because of the antagonist spirit of our physicians and because of the apathy demonstrated by many of them when they are asked to improve their way of

The situation remained tenuous for a number of years. In December 1928, the chronicles revealed: "Patient care would be better if interns and physicians were more ambitious. It is difficult to implement change because the medical staff lacks unity and cohesiveness." In November, 1930, the sisters were informed that the EGH had lost its *Grade A* standing.[268] The College of Surgeons was not satisfied with the medical staff organization and it was stated that physicians' charting was below the standard. Nursing care was judged to be very appropriate.[269] Improvement was not immediate, but in December the physicians adopted new regulations. By April, 1931, the College indicated that if improvement continued and an orthopaedic surgeon was hired, the hospital would regain its *Grade A* standing.[270] Although, it took until December, 1931 for the physicians to accept the need for an orthopaedic surgeon,[271] it may have been the case that by then they realized that non-compliance could have serious consequences. In addition, seeking solutions to the problems occasioned by the economic depression

---

functioning.

[266] ASGME, EGH, Chroniques, 11 April and May 2 1927.

[267] The only cases in which the sisters refused physicians the privilege to practice at the EGH were all related to the practice of abortions.

[268] ASGME, EGH, Chroniques, November 1930.

[269] ASGME, EHH, Doc. 126. Letter of Franklin H. Martin, director of the American College of Surgeons to Sister Duckett, Superior of the EGH, Chicago, 24 September 1930.

[270] ASGME, EGH, Chroniques, December 1930 and April 1931.

[271] Ibid., December 1931.

probably played a unifying role. Monthly minutes of medical meetings began to be recorded in 1933 and in 1934 the hospital regained its *Grade A* standing.[272]

The economic depression

Unemployment

The economic depression was acutely felt in the Canadian Prairies. The drop in wheat prices and a severe drought in southern Alberta and in many areas of Saskatchewan had devastating consequences for rural areas. Because of their role as wholesale centres, both major cities of Alberta were also strongly affected. Unemployment rose and bankrupt farmers and rural workers sought relief in the cities where unemployment was already high.

The early 1920's had been quite prosperous and Edmonton's population had increased from 59,000 in 1921 to 79,000 in 1931.[273] However, during the early 1930's 25% of the population became unemployed. It has been estimated that in 1931, approximately 2,600 families out of 18,000 were receiving relief and that in 1932, 13% of the citizens relied entirely on public assistance. Edmonton could not cope with more unemployed and in 1931 the Council prohibited transients from staying within the city limits:[274] "As day after day these itinerants from the south and the east rolled their wagons into Edmonton, the authorities provided them with hot soup and other food and sped them on their way north, wagon loads of them. Sorry as Edmontonians were for them, they were glad to see them urge their horses out of the city."[275]

Racial tension

Significantly, the dormant racial hatred was reactivated in the late 1920's. During that decade immigration from Eastern Europe had been significant and interest groups opposed to the arrival of people from this part of Europe had been developing.[276] In particular, these groups claimed that these immigrants would destroy the Anglo-Protestant fabric of Canada since they were allies in a French Canadian Catholic plot to undermine the British character of the country.[277] Although the Klu Klux Klan (KKK) was stronger in Saskatchewan than in Alberta, its presence constituted a threat especially in Edmonton. The Alberta KKK leader, J.J. Maloney (from Ontario), had selected the capital as his headquarters and he successfully recruited between 5,000 and 7,000 members during the late 1920's and early 1930's. Maloney called Edmonton

---

[272] ASGME, MMSM, 15 October 1934.

[273] Palmer and Palmer, ***Alberta a new history***, 209.

[274] Ibid., 218.

[275] MacGregor, ***Edmonton, A history***, 243.

> ... the *Rome of the West* because of its concentration of Roman Catholic ecclesiastical institutions, [he] attempted to instigate boycotts of catholic businessmen, prevent religious intermarriage, intimidate politicians who "catered to Rome" [the Liberals], combat the use of the French language, and stop continental European immigration.[278]

The KKK did at least two cross burning rituals in Edmonton in the early 1930's. A cross was burned following the election of a Conservative member of parliament in the federal election of 1930,[279] and in 1931, another one was set on fire to celebrate the electoral defeat of Mayor Douglas who was seen as a Catholic supporter.[280] The Grey Nuns were well aware of the Klan's activities. At the 1932 school of nursing graduation the Lieutenant Governor made fewer comments than usual about the value of Catholic institutions. In the chronicles, it was stated that the low key address of the Lieutenant

---

[276] Among these groups were the National Association of Canada (lead by an Anglican bishop), the ultra-Protestant Orange Order and the Ku Klux Klan. Palmer and Palmer, ***Alberta a new history***, 203.

[277] Ibid., 304.

[278] Ibid., 204.

[279] Ibid.

[280] ASGME, EGH, Chroniques, November 1931.

Governor was probably linked to the "anti-Catholic fanaticism led by J.J. Maloney."[281] Fortunately the KKK did not survive the depression years.[282] However, its presence during the early 1930's was an additional source of worry for the sisters who already had many preoccupying problems.

The Edmonton Hospitalization Group Plan

However, the depression years brought a positive development in the hospital world of Edmonton. In 1934, under the leadership of Dr. A.F. Anderson of the RAH and Dr. R.T. Washburn of the UAH the four general hospitals of the city established the Edmonton Hospitalization Group Plan. This plan was the first hospital insurance program developed in Canada.[283] The instigators reasoned that if participation in an insurance plan had been possible, hospital services would have continued to be affordable and accessible for those who were insured. Believing that it was possible to create such a plan Dr. Anderson and Dr. Washburn shared their views and successfully convinced the administration of the four hospitals to organize a prepayment plan. Although not universal in scope, the plan covered workers via group insurance and premiums were collected by payroll deductions. Monthly rates consisted of $0.60 per worker, plus $0.55 per adult dependent and $0.25 for each child.[284]

Provincial politics

At the provincial level, an important effect of the depression was the defeat of the United Farmers of Alberta Government and its replacement by the Social Credit Party in the election of 1935. William Aberhart, the leader of this party, believed that economic reforms were necessary and that the depression had been caused by a shortage of purchasing power. For him, monetary reform was necessary and he advocated further the replacement of money as the motivating force in human behaviour.[285]

---

[281] Ibid., 25 May 1932.

[282] Palmer and Palmer, ***Alberta a new history***, 204.

[283] Agnew, ***Canadian hospitals***, 156-157; The plan was so successful that in 1948 it was used to guide the establishment of the Provincial Blue Cross Plan. Brown, "The evolution of hospital funding," 42.

[284] Brown, Ibid., 60.

The effect of the depression on the EGH

The 1930's depression had a direct impact on the EGH operations. Financial problems became acute and construction plans had to be postponed. Admissions to private rooms decreased and patients using public wards were poorer than in the past.[286] The maternity department was particularly affected and the sisters attributed the rise in home births to the generalized poverty.[287] In 1933, the Grey Nuns decided to hire a collection agent. The chronicles recorded that the goal was not to be hard on poor people, but to ensure that patients would give what they could and that reimbursement plans would be established.[288] The decrease in municipal grants and the low bed occupancy must have increased the urgency of eliminating unpaid accounts of discharged patients.

The search for contracts

Beginning in 1930 the sisters sought to obtain special contracts that would ensure a more regular patient intake. In March of that year the department of national defence was approached without success.[289] However, in January 1931, they secured a contract with the municipality of Onoway which pledged to use the EGH for surgical cases.[290] Unfortunately, census problems took a new form in August 1931 when the provincial inspector condemned the third and fourth floors of the 1895 building.[291] In his report, the inspector stated that fire regulations were clearly posted but that because of the age of the building and the type of construction a fire would spread rapidly. He proposed that tubular fire escapes be built. However, until then admission of patients above the second floor would be forbidden.[292] The sisters had no alternative but to comply. Patients were transferred to the nursing students' residence and the students moved to the old building; tubular fire escapes were built in 1932.[293] However, it was found that some of the space in the old building remained vacant even after the addition of the new tubular fire escapes. It thus seems that the department considered that even though these fire escapes had been built, the space was still not suitable for patient use.[294]

---

[285] John, A. Irving, ***The social credit movement in Alberta***, (Toronto: University of Toronto Press, 1959), 51 and 231.

[286] ASGME, EGH, Chroniques, 1932; In 1927 the average census was around 200 patients. Between 1931 and 1934 the number of patients was rarely greater than 125. These figures were found in the hospital annual reports.

[287] Ibid., February 1933.

[288] Ibid., January 1933.

[289] Ibid., March 1930.

[290] Ibid., January 1931.

Creation of an advisory board

It was not possible to determine the number of beds lost because of this situation. However, it must have been significant since it seems that this additional problem triggered the creation of an advisory board. Indeed, in June, 1931, two months after the fire inspection, four businessmen met with the Provincial Superior to discuss the possibility of establishing a board. A month later, the first board meeting was held and Milton Martin was elected President of the new EGH Advisory Board.[295] The initial tasks of the board could not be determined, but it is likely that its members might have been consulted about the ward closures and the general financial situation. Since Mr.

---

[291] Since 1919 a provincial representative inspected all hospitals once a year. Department of Public Health of the Province of Alberta. ***History, administration, organization with work of the Provincial Department of Public Health and Board of Health***, (Edmonton: Author, 1937), 3.

[292] The fifth floor of the building continued to be used as the sisters' living quarters. ASGME, EHH, Doc. 127, Report of R. Moore provincial inspector for the Government of Alberta office of fire commissioners, Hospital Inspection Section. 14 March 1931.

[293] ASGME, EGH, Chroniques, January, August and December 1932.

[294] Ibid., 1938.

[295] Ibid., June and July 1931; Milton Martin was also a member of the Misericordia Hospital's Advisory Board. John Gilpin, ***The Misericordia Hospital***, 71.

Martin was an insurance agent, his advice might have been sought in respect of the fire inspection report. As all other advisors were also well known Edmontonians, the sisters may have relied upon their business skills to try to obtain contractual agreements for the hospitalization of patients.

The tuberculosis contracts

In March 1932, the sisters contacted the deputy minister of the department of health, Dr. Bow, to ask if a contract could be given to the EGH in respect of the admission of patients with tuberculosis (TB). The Superior based her request on the fact that the Calgary sanatorium was unable to provide care to the ever increasing number of patients who had the disease. In addition, she stated that people of northern Alberta did not have the same level of service as those who resided in the southern portion of the province. The deputy minister promised to consider the offer.[296] Although success was not immediate, an agreement was reached four years later. In 1936, the new Social Credit provincial government had realized the magnitude and seriousness of tuberculosis in the province and a tuberculosis act was promulgated. This act included a provision to make agreements with hospital boards, as a means of increasing the number of available beds for people who had that disease. Most important, the act included the provision that the hospitalization costs of TB patients would be entirely covered by the province.[297] On July 1, 1936, the EGH was granted a government contract for the hospitalization of TB patients and 65 beds were set aside for the purpose.[298] A year later the province showed its satisfaction with the services rendered at the EGH by requesting an additional 40 beds for TB patients. Although the sisters agreed, the decision to increase the number of TB beds must have been a difficult one since finding the necessary space required a reorganization of patient services. In order to provide the necessary space, the Grey Nuns opted to close the maternity service.[299]

---

[296] ASGME, EGH, Chroniques, March 1932.

[297] Statutes of Alberta, ***The Tuberculosis Act***, (Edmonton: Province of Alberta, 1936), Chapter 50.

[298] ASGME, EGH, Chroniques July 1936; The UAH and the RAH also signed TB contracts but the number of beds was limited (less then 20).

From a financial standpoint the decision to close this department was probably the most logical decision which could have been made. In the depressed economy of the time, hospital delivery was viewed as a luxury and the unit census had been low. Nevertheless, closing this department was not without consequences. It meant that the director of the school of nursing had to find an affiliating agency for the obstetrical experience of the students. For many of the same reasons, the sisters had thought of eliminating the pediatric service. They decided to keep a small 16 bed unit in order to be able to continue to provide a pediatric care experience to student nurses.[300] Ensuring that these students were given sufficiently varied clinical experiences was essential to the survival of the school. If the sisters had elected to entirely close the pediatric service, the students would have only been left with adult medical/surgical experience on site. It therefore would have been difficult to justify the existence of the school, and in turn the future of the EGH might have been jeopardized since a student workforce was necessary to ensuring a nursing service in the institution. Thus the sisters had to balance the future with the present in ensuring that the EGH admitted enough patients for its immediate survival. This equilibrium was difficult to achieve and the large number of TB patients did have a negative impact on enrolment in the school of nursing.[301] In 1938, a final increase in the number of TB beds occurred. Interestingly, in order to satisfy the demand, the province decided to reopen beds which had been condemned in the early 1930's.

By the end of this era, at least more than half the hospital beds were used for TB patients.[302] Although the EGH was still considered a general hospital, the elimination of of the obstetrical department and the reduction of the pediatric service compromised this status. The Grey Nuns were willing to offer services to TB patients, but decisions which were made in the following decade clearly show that they intended to preserve the initial mission of the institution.

---

[299] ASGME, EGH, Chroniques, July 1937.

[300] Ibid.; EHH, Doc. 147.

[301] More details are provided in the chapter on the school of nursing.

[302] Ell, "Edmonton General," 40. The exact number of TB beds could not be determined. However, since the hospital had 200 beds and by 1937, 105 were designated for tuberculosis cases, it is evident that more than half of the beds were used

Sources of financial support

Gifts in kind and citizens donations

The only available information about donations was found in the *Livre de Caisse* where Christmas donations were sporadically recorded between 1919 and 1939.[303] The results presented in Table 9 show the value of Christmas gifts for selected years. It is clear that the amounts given were consistent with the economic climate. The maximum was reached in 1926, the minimum in 1932 and the value of donations began to increase by 1933. Details about donors were not available to the same extent has they had been for the previous era. However, there is no reason to believe that support did not come from a similar pool of individuals.

TABLE 9

CHRISTMAS GIFTS FOR SELECTED YEARS
BETWEEN 1926 AND 1938

Year	Nature	Money	Total
1926	$225.62	$297.38	$552.90
1929	$139.50	$384.00	$523.50
1932	$85.30	$122.50	$207.80
1935	$136.16	$164.50	$300.60
1938	$213.26	$170.50	$388.76

Municipal support

The chronicles and the annual reports revealed that in the late 1920's the city gave

---

for that purpose.

[303] Information was in fact available only between 1926 and 1938.

approximately $10,000.00 a year to the EGH.[304] However, the economic depression had a direct effect on municipal grants. In 1932, the city of Edmonton pledged only $2,800.00 and in 1936 municipal support was limited to approximately $4,500.00.[305] It is thus evident that the EGH could not count on much municipal support during the depression and that even towards the end of the period, funding was still lower than during the prosperous late 1920's. In itself the decrease in municipal grants confirms that the search for regular contracts had become necessary.

Provincial and federal support

In 1920 the province increased the *per diem* of the hospital to 50 cents a day.[306] It is unlikely that this rate was further increased during the remaining years of that era. However, as noted above, in 1936 the province began to offer full financing for the hospitalization of patients who had tuberculosis. Considering that by 1938 more than half of the beds were used for that purpose, it is evident that a substantial proportion of hospital income must have been derived from that service.[307] Finally, there is no indication that the federal government increased its rate of support to the health care sector.

Hospital budgets

Results presented in Table 10 provide information about the operating budgets of 1920-1921, 1925-1926, 1930-1931, and 1935-1936. The data clearly shows the magnitude of the economic depression. Notably, the income in 1935-1936 was lower than it had been in 1918-1919. The decrease in income was directly linked to the significant decrease in the number of admissions. For example, the average daily census of 1927 was about 200 patients; in 1934 it had fallen to 125, and by 1936 it was still only 156. In 1938, the hospital must have been on the road to recovery since the average daily census had risen to 200 patients.[308]

---

[304] ASGME, EGH, Chroniques 1932; annual reports of 1925 to 1929.

[305] ASGME, EGH, Chroniques, 13 April 1932; annual report of 1936.

[306] Juzwishin, "A history of the Alberta Hospital Association," 33.

[307] The proportion of governmental support could not be established since budgets were not available for 1937 and 1938.

TABLE 10

OPERATING BUDGETS OF 1920-1921,
1925-1926, 1930-1931 AND 1935-1936

	1920-1921	1925-1926	1930-1931	1935-1936
Income	$322,617.33	$196,932.50	$115,878.87	$90,071.11
Expenses	$314,502.59	$192,524.74	$114,069.65	$88,936.55
Surplus	$8,114.74	$4,407.76	$1,809.22	$1,134.56

Assets and liabilities also reflected the economic climate of the time (See Table 11). In particular, the debt increased by $18,000 between 1931 and 1936. This rise can be considered unusual since no major construction had been undertaken in these years and normally money was borrowed for that purpose. It is thus apparent that the difficulties were linked to the depression and that the sisters had to borrow to maintain the daily functioning of the hospital. Although the exact use of these funds could not be determined, it is known that a portion was used to pay suppliers.[309] The value of the property also depreciated significantly between 1931 and 1936. Part of this depreciation may have been linked to the depression. However the largest proportion of the decline must have been due to the deterioration and age of the 1895 building which had led to the enforced closure of two floors in 1931.

---

[308] ASGME, EGH, Chroniques; annual reports 1927 to 1938.

[309] ASGME, Hôpital Edmonton, Visites canoniques 1896-1953. Visit of 1934, 52-54.

TABLE 11

ASSETS AND LIABILITIES IN 1921, 1926, 1931 AND 1936

	1921	1926	1931	1936
ASSETS				
Building and land	$577,000.00	$632,070.58	$632,070.58	$373,048.78
Supplies	$68,000.00	$68,000.00	$68,000.00	$43,729.46
Other	$1,438.06	$2,562.22	$1,809.14	$1,164.37
TOTAL	$646,438.06	$705,071.81	$701,879.72	$417,942.61
LIABILITIES				
To Motherhouse	$37,000.00	$127,000.00	$130,000.00	$150,000.00
To others	$113,385.42	$96,200.00	$67,600.00	$65,600.00
TOTAL	$150,385.42	$223,200.00	$197,600.00	$215,600.00
NET SURPLUS	$496,052.64	$481,871.81	$504,279.72	$202,342.61

As in the previous period, the list of creditors consisted primarily of French Canadian institutions and French Canadian individuals (See Table 12). The Motherhouse was the most important creditor accounting for 56.9% of the debt in 1926 and 69.6% of the debt in 1936. Although Montreal was also affected by the economic depression, it is evident that the accumulated wealth of the Motherhouse was sufficient to support the administrators of institutions where financial problems were more acutely felt. Keeping more than 50% of the debt within the Order was deemed essential especially in times of economic uncertainty. In this manner, the Grey Nuns could protect the various houses of the network from undesirable takeovers.[310]

---

[310] Personal communication with Sister Estelle Mitchell, historian of the Grey Nuns' Order, 19 October 1993.

TABLE 12

CREDITORS 1921, 1926, 1931 AND 1936

CREDITORS	1921 Amount (Rate)	1926 Amount (Rate)	1931 Amount (Rate)	1936 Amount (Rate)
Carmélites St. Boniface		$16,500.00 (6%)		
Carmélites Trois-Rivières			$15,000.00 (6%)	
Crédit Foncier of Edmonton	$49,000.00 (7%)	$20,000.00 (7%)		
Daughters of Jesus, Morinville		$7,000.00 (6%)		
French Canadian Individuals *	$28,200.00 (6%)	$31,800.00 (6%)	$37,200.00 (6%)	$46,600.00 (5%)
Motherhouse Montreal	$37,000.00 (7%)	$127,000.00 (6%)	$130,000.00 (6%)	$150,000.00 (5%)
Oblates of St. Albert				$6,000.00 (5%)
One priest		$9,500.00 (6%)	$4,000.00 (6%)	
Sacred Heart Hospital, Fort Providence	$11,400.00 (4%)	$11,400.00 (4%)	$11,400.00 (4%)	$13,000.00 (4%)
St. Albert's Parish, St. Albert	$9,000.00 (6%)			
St. Joseph's Parish, Edmonton	$9,000.00 (7%)			
Suppliers	$6,785.42 (?%)			
TOTAL	$150,385.42	$223,200.00	$197,600.00	$215,600.00

* 1921 and 1926: Two individuals; 1931: Four individuals;
1936: Eight individuals (four from the same family).

The results presented in Tables 13 and 14 provide details about income and expenses for the years of 1920-1921, 1925-1926, 1930-1931 and 1935-1936. It is evident that the depression had a negative effect on almost all areas of income/expenses. However, a comparison of the results of this era with those of the previous period of time show that new and long lasting trends were beginning to emerge. In particular, in respect of income, the proportion provided by governments (most of the change can be attributed to the provincial level) greatly increased from around 10% in the previous era to approximately 20% in the 1930's. Although this should not be interpreted as a doubling of governmental rates, a trend towards a greater reliance on state funding was emerging.

TABLE 13

INCOME IN 1920-1921, 1925-1926,
1930-1931 AND 1935-1936

SOU.	1920-1921 Amount (%)	1925-1926 Amount (%)	1930-1931 Amount (%)	1935-1936 Amount (%)
Ban.	$22,141.52 (6.86)	$1,177.82 (0.59)	$869.72 (0.75)	$1,069.22 (1.19)
Bor.	$165,500.00 (51.29)	$79,300.00 (40.27)	$10,000.00 (8.63)	
Cit.	$5,166.58 (1.60)	$9,625.00 (4.89)	$9,625.00 (8.31)	$4,461.50 (4.95)
Far.	$3,735.77 (1.16)	$2,942.43 (1.49)	$1,402.17 (1.21)	$401.35 (6.44)
Gov.	$20,359.50 (6.31)	$21,624.50 (10.98)	$23,447.08 (20.23)	$19,157.50 (21.27)
Nur.	$1,111.00 (0.34)			
Pat.	$99,657.70 (30.90)	$81,675.10 (41.47)	$67,747.90 (58.46)	$64,136.77 (71.21)
Oth.	$4,927.06 (1.53)	$587.65 (0.30)	$2,787.00 (2.41)	$844.77 (0.94)
TOT.	$322,617.13 (100)	$196,932.50 (100)	$115,878.87 (100)	$90,071.11 (100)

N.B. After 1929, the EGH no longer had farm animals; farming activities were limited to gardening. Abbreviations used: Bank (Ban.), Borrowed (Bor.), City (Cit.), Farm (Far.), Government (Gov.), Nursing (Nur.), Other (Oth.), Patients (Pat.), Source (Sou.) and Total (TOT.).

TABLE 14

EXPENSES IN 1921-1921, 1925-1926 1930-1931 AND 1935-1936

SOU.	1920-1921 Amount (%)	1925-1926 Amount (%)	1930-1931 Amount (%)	1935-1936 Amount (%)
Con.	$171,394.82 (54.50)	$63,320.79 (32.89)	$2,825.88 (2.48)	$5,871.92 (6.60)
Far.	$493.03 (0.16)			
Foo.	$24,532.21 (7.80)	$33,649.14 (17.48)	$33,530.93 (29.39)	$21,876.40 (24.59)
Ins.	$1,299.47 (0.41)	$715.97 (0.37)	$2,087.47 (1.83)	$1,925.21 (2.16)
Int.	$6,488.43 (2.06)	$12,567.96 (6.36)	$11,453.01 (10.04)	$8,817.88 (9.91)
Leg.	$983.50 (0.31)	$882.29 (0.46)	$102.00 (0.09)	$165.63 (0.19)
Loa.	$37,100.00 (11.80)	$31,500.00 (16.36)	$10,500.00 (9.20)	$500.00 (0.56)
Mot.	$3,900.00 (1.24)	$4,246.17 (2.20)	$5,933.00 (5.20)	$5,156.75 (5.79)
Sal.	$15,020.08 (4.78)	$20,271.34 (10.53)	$26,689.36 (23.40)	$23,664.43 (26.61)
Sup.	$35,722.91 (11.36)	$12,307.05 (6.39)	$10,313.12 (9.04)	$8,898.90 (10.01)
Tax.	$1,024.55 (0.32)	$1,030.06 (0.53)	$265.99 (0.23)	$878.73 (0.99)
Uti.	$16,121.01 (5.12)	$11,236.70 (5.84)	$9,131.82 (8.01)	$10,067.49 (11.32)
Oth.	$422.58 (0.13)	$797.27 (0.41)	$1,237.07 (1.08)	$1,113.21 (1.25)
TOT.	$314,502.59 (100)	$192,524.74 (100)	$114,069.65 (100)	$88,936.55 (100)

Abbreviations used: Construction (Con.), Farm (Far.), Food (Foo.), Insurance (Ins.), Interest (Int.), Legal fees (Leg.), Loans (Loa.), Motherhouse (Mot.), Other (Oth.) Salaries (Sal.), Sources (Sou.), Supplies (Sup.), Taxes (Tax.), Total (TOT.) and Utilities (Uti.).

In terms of spending, the most important variation in comparison with the previous era was the increasing importance of salaries. Until 1921 salaries comprised less than 10% of the budget, while in 1936 they comprised a little more than 25% of the total expenses. It is interesting that this occurred even though a small reduction in the net amount spent on salaries was noted between 1930-1931 and 1935-1936.[311] However, the increasing importance of salaries did not mean that employees were better paid. Rather it was most likely that a larger work force was needed to ensure the functioning of the hospital.[312]

---

[311] The reason for the difference could not be established. It may be suggested that employees might have left and that because of financial difficulties it might have been

In conclusion, the period of 1919-1938 consisted of good and bad years. The first ten years were fairly prosperous, construction was undertaken and the hospital received its first accreditation certificate. However, these years were followed by a very difficult period of time during which the future of the EGH became uncertain. The economic depression had a profound impact on the hospital and by 1937 half of the beds were occupied by TB patients. It is legitimate to wonder if the EGH could have survived if the sisters had not had decided to seek a contract with the government for the care of TB patients.

---

decided to keep their positions vacant.

[312] Results presented in the chapter on the hospital workforce show that the mean number of employees more than doubled between the 1905-1918 period and the 1919-1938 era.

CHAPTER 9

FROM WAR TO PROSPERITY: 1939-1957
TOWARDS A NEW HEALTH CARE SYSTEM

The 18 years which comprise the period from World War II (WWII) to the establishment of formal legislation to create national health insurance in Canada are important because they were a prelude to the fundamental changes which took place in the Canadian health care system during the next era. WWII usurped the world stage for seven years. Its most important manifestation in the hospital took the shape of chronic shortages of staff. However, the depression years had been so difficult for the EGH that the effect of WWII seemed marginal by comparison. In fact the hospital expanded and gained a new financial stability during this time and by the end of the worldwide conflict, prosperity was on the its doorstep. The immediate postwar years saw the beginning of the development of a social safety net the purpose of which was to ensure that the horrors of the 1930's would never be repeated. The economic prosperity of these years permitted the establishment of a number of federal programs and Canada engaged in a long period of continuous growth.

Albertans had their own reasons for optimism. The discovery of oil in 1947 at Leduc gave a tremendous kickstart to the economy. Edmonton and Calgary directly benefited from the new wealth. As the centre of the drilling industry, Edmonton claimed to be the "Oil Capital of Canada", but the label fitted Calgary just as well since it was becoming the financial centre of the oil industry. Importantly, Edmonton and Calgary surpassed Winnipeg in economic dominance, the latter city losing its title of most important urban centre of the Prairies. The growth of Edmonton and Calgary accelerated the shift of Alberta from rural to urban society.[313]

Administrative structure

Five superiors oversaw the destiny of the EGH during this period of time. Although the Grey Nuns maintained their control, the administrative structure became more complex. Nursing service and nursing education became distinct entities in 1955.[314] This step was neither the first nor the last in the long process which led to the division of the two services. Yet, the creation of the position of director of nursing service was a crucial change since from then on the director of the school exclusively devoted her time to educational and administrative matters linked to the education of student nurses.[315] The involvement of lay people in decision making took on greater proportions especially in the last decade of this period. Lay nurses were given charge of nursing units, lay men were hired at the higher middle-management levels and physicians played a more prominent role in the administration of the hospital. In particular, the presence of strong leaders within their ranks contributed to the rising influence of the medical staff. The trends which were emerging can be linked to a number of factors. Importantly, the increasingly limited availability of religious personnel meant that more responsibilities had to be delegated to lay employees. The concomitant increasing complexity of the hospital world also made necessary the expansion of administrative services and required that administrators be more substantively prepared to fulfil their roles.

---

[313] In 1950, a little more than half of the population of Alberta lived in cities. By 1970, 70% of the population was urban. Palmer and Palmer, ***Alberta a new history***, 300.

Administrative issues

The need to expand and improve the physical plant of the hospital was a recurrent and primary concern throughout the period. The prospect of a national hospitalization plan was also a salient issue especially after WW II, as were labor relations and shortages of staff.[316] The construction of two permanent buildings in 1940 and 1953 and the addition of a temporary unit in 1948 were necessary for a number of reasons. As in previous years, the growth of Edmonton coupled with financial considerations including competition with other hospitals, were key factors which pushed the Grey Nuns to invest further in their property. Construction planning data unequivocally shows the importance of these factors. However, documents pertaining to the topic have additional value because they include information which lends support to the assertion that lay individuals became more involved in administrative issues, and because they shed light on the decision making role of the Motherhouse.

---

[314] ASGME, Edmonton General Hospital, History of the school of nursing (HSN), 1955.

[315] This topic is addressed in the chapters on the School of Nursing and on patient care delivery.

[316] Labour relations and shortages of staff are addressed in the chapter on the EGH workforce.

The 1940 building

The new five storey building of 100 beds which opened in 1940 was the result of long negotiations which had taken place between the EGH administration and the Motherhouse. It has been seen that the rapid increase in the number of TB beds had reduced the number of beds available for general care. In September 1937, the Provincial Superior, Sister Casey and the EGH Superior, Sister Fortin requested permission to build. Within a month's time a positive reply had been received from Montreal and by December an architect had been selected.[317]

However, in May 1938 the Provincial Superior was informed that the architect's plans would have to be approved by the General Council (Motherhouse) and that final permission would be given only once it was established that the debt on the 1920's construction had been lowered in the previous three years.[318] Consequently, in July 1938 the architect went to Montreal to present his plans for the addition of two wings to the EGH. Following his visit, the General Council informed the EGH superior that the cost was too elevated at $660,000.00 and suggested limiting the construction to only one wing. In light of this, the Edmonton sisters eliminated the wing which was supposed to include a new kitchen and chapel. The chronicles stated that they believed that this was the best alternative, since that way the number of new patient beds would not be affected and the cost would be reduced to $475,000.00.[319]

This reduction still did not satisfy the Montreal authorities, and in October 1938 the EGH administration was informed that the project had been entirely rejected.[320] This rejection must have been expected since in September a member of the General Council had written to one of the provincial councillors in St. Albert letting her know that she had not been able to convince her colleagues that the EGH should be given permission to build. She wrote:

---

[317] ASGME, EGH, Chroniques, September, October and December 1937.

[318] Ibid., May 1938.

[319] Ibid., August 1938.

> La majorité exprime l'opinion que cette institution ne pourra pas financer un tel emprunt, puis Mère Allaire est toujours à nous présenter le spectre de "l'hôpital état" lequel procédé conduirait nos hôpitaux à la banqueroute. Je ne partage pas ses idées, je ne vois pas les choses comme elle, mais je ne suis qu'une voix. Je ne vous cache pas que les articles de nos quotidiens contre le gouvernement d'Aberhart, ne vous font aucun bien. Inutile d'ajouter que, connaissant vos besoins et ayant à coeur le développement de cette oeuvre, je souffre avec le conseil provincial des lenteurs et des peurs du conseil.[321]

This letter is most enlightening because it shows that the Grey Nuns Order reflected characteristics of large financial corporations. In particular, major decisions were taken by a general council whose members did not always have convergent views. In this case, Sister Laberge supported the Alberta administration and attempted without success to influence the decisions of her colleagues. It is evident that the Council feared that the EGH would not be able to repay the building loan even if the debt had been reduced in the previous few years. The financial situation remained a cause for concern. However, past experience had shown that expansion could lead to financial recovery; the profits made after the construction of 1916 were a concrete example of the phenomenon.

---

[320] Ibid., October 1938.

[321] ASGME, EHH, Doc. 149. Letter of Sister Laberge to Sister Beaupré of St. Albert, Montreal, 7 September 1938; Quote translation: The majority is of the opinion that this institution [the EGH] will never be able to finance such a loan. In addition, Mother Allaire is always bringing up the spectre of "state hospitals" which would lead our institutions to bankruptcy. I do not share her views, I do not see things in the same way, but I am only one voice. It is evident that the publication of articles against the Aberhart government in the local press does help your cause. It is not necessary to add that knowing your needs and having at heart the development of the hospital, I suffer with your provincial council of the slowness and fear of our council.

Even if this might have been considered a valid reason to favour expansion, the immediate context included factors that were perceived as strong deterrents. Two factors were mentioned in the letter: the fear of greater state involvement in hospital matters and the political climate of Alberta. The first factor was a constant preoccupation which is addressed in later pages. Suffice it to write that many believed that the movement towards "state hospitals" was linked to the communist vision of the world, a vision particularly feared by the Roman Catholic Church and the Quebec politicians of the time. To make matters worse many considered that the Alberta government had communist allegiances which magnified those fears.

The election of a Social Credit government in Alberta in 1935 had "... attracted puzzled attention across the English-speaking world. A Boston newspaper was headlined "Alberta Goes Crazy."[322] In particular, because of the attack on the banking industry, the incumbent Social Credit Government was perceived as a threat to capitalism. Thus, it is not surprising that journalists along with liberal and conservative politicians from all parts of the country accused Aberhart and his party of being communists.[323] Influenced by the media hype the General Council must have believed that since Aberhart was a communist he was a threat to their Alberta hospitals.

Obviously the Alberta sisters did not share these fears and they did not accept the decision made by the General Council. In November 1938, the denial was discussed with the members of the advisory board.[324] Although the minutes of this meeting could not be found, it is logical to assume that a plan of action was designed to contest the decision. It is also evident that the General Council agreed to reconsider the decision, since in December 1938 a detailed questionnaire was sent to the provincial house.[325] Five questions were asked and were answered by the Alberta Sisters:[326]

---

[322] Palmer and Palmer, ***Alberta a new history***, 268.

[323] J. F. Conway, ***The West, the history of a region in confederation***, (Toronto: James Lorimer & Company Publishers, 1984), 120-125.

[324] ASGME, EGH, Chroniques, November 1938.

1. What would be the consequence of postponing construction?

- The RAH has been denied the permission to build. The City Council argued that the EGH expansion would satisfy Edmonton's need for more beds. The RAH is planning to appeal this decision and if they realize that our plans are compromised, they might win their appeal. The resulting expansion of that hospital would make us lose even more money.
- A local group of physicians who operate a large clinic would like to use our hospital. If we postpone construction they will approach another facility.
- Under the leadership of our Bishop, a group of Catholic physicians is being formed and they wish to use the services of a Catholic hospital. If we do not build they will go elsewhere.
- We are very short of space and the physicians are frustrated by the situation. In particular, we need more private rooms which, as you know, can significantly increase a hospital's income.
- Some patients are afraid to come to the EGH because general services are contiguous with TB services.
- Postponing construction would be detrimental to the School of Nursing. Many potential students from the city choose other schools where their education in enriched by more varied clinical experiences. Obstetrical affiliations are difficult to find since other hospitals consider that the presence of our students reduces the number of experiences available to their own students. The small pediatric service causes similar problems. Five of our students failed the pediatric component of their professional nursing exam and we believe that this is due to the reduced diversity of pediatric experiences.

---

[325] ASGME, EHH, Doc. 154, Questionnaire sent by Sister Labrosse of the Motherhouse to Sr Beaupré provincial councillor of St. Albert, 23 December 1938.

[326] ASGME, EHH, Doc. 155, Completed questionnaire sent to Montreal, 14 January 1939; free translation.

- In general, the public and the physicians show understanding; however, there is a limit to their patience.

2. If you build now, how will you deal with the resulting debt and with the accumulated debt?

- We are hopeful that the sanatorium contract will be renewed. Since 1936, the income generated by this service as permitted us to decrease our debt of $91,000.00, with a remaining debt of $125,000.00 on January 1, 1939.

- The sanatorium income also permitted the purchase of $8,500.00 worth of equipment.

- We believe that the sanatorium will generate a yearly surplus of $68,000.00.

3. Where did the surplus of the last three years came from?

- Mostly from the tuberculosis contract.

4. Can you count on the TB service as a long term source of income?

- The other hospitals of Edmonton do not seem interested to increase the number of beds used for the care of TB patients.

- We owe our TB service to the Social Credit government. In the event that the Social Credit lost power in the next election we have been assured by well informed individuals that the province cannot afford to build a sanatorium and thus our contract would continue to be renewed.

- The physician in charge of our TB service has on many occasions told us that he is impressed by the care given by the sisters and the student nurses.

- The province is also satisfied and the inspector congratulates us on each of his visits.

5. Are you counting on the Motherhouse for financial assistance? What type of support do you need?

- We are asking for your moral support.

- We also hope that you will negotiate our loan and guarantee our mortgage. However, this request is based on the premise that we are confident that we will be able to fulfil our financial obligations.

The answers given show that the Alberta sisters used six factors to convince the General Council: the competition between Edmonton hospitals, the need for more beds as based on the physicians' requirements, the needs of Catholic citizens, the requirements of the School of Nursing, financial considerations and the importance of the tuberculosis service. The answers were also designed to demonstrate that the various factors were not independent of each other.

The competition factor was used to demonstrate that the EGH needed to build in order to survive and to be financially profitable. In addition, the manner in which the RAH situation was presented provided evidence that new beds were needed in Edmonton. The multiple references to physicians' requirements also led to the same conclusion and added the dimension of competition between the two Catholic hospitals of Edmonton. Including the catholic dimension suggested that increasing the size of the EGH would enable the sisters to provide better services to their target population. The educational needs of the nursing students were also presented in a manner which reinforced the fact that competition existed between Edmonton's hospitals.

Problems associated with a large tuberculosis service were used to justify construction. The fears of some patients about using the EGH because of the contiguity of general and TB beds reinforced the idea that more beds were needed and as so did the description of the effect of the service on the School of Nursing. However, the TB contract was also used to demonstrate that the EGH administration would be able to repay future loans. Stating that the EGH owed this contract to the Social Credit government was an effective way of reducing the fears of the Councillors in respect of the provincial government of Alberta. Similarly, the consequences of impending provincial elections were addressed to reinforce that the sisters could count on a long term TB contract. It appears that the sisters used almost all possible means of convincing the General Council. However, it is surprising that serving the French Canadian population was not used as a justification for expansion. It may be that this aspect was assumed in alluding to the Catholic population.

The sisters did not remain idle while waiting for an answer from Montreal. The support of the local Bishop was requested and on February 20, 1939 he shared the letter he was sending to the Motherhouse with the EGH superior.[327] It is thus clear that

---

[327] ASGME, EGH, Chroniques, 20 February 1939.

Bishop MacDonald collaborated with the EGH superior in providing evidence supporting the need to build. In addition, on March 13, 1939, Dr. L.P. Mousseau, Mr. Gallant and Mr. L. Maynard met with the Minister of Health to request a five year renewal of the TB contract. The minister was very supportive and a ten year contract was granted.[328] Of interest, the superior had delegated three men for this task. This supports the assertion that lay individuals were becoming increasingly involved in administrative issues. The selection of these three individuals reveal political clout as well as Franco-Albertan solidarity. Dr Mousseau was a prominent EGH physician and a respected French Canadian member of the medical profession. Lucien Maynard was a French Canadian lawyer and importantly was the Social Credit Member of the Legislative Assembly from Beaver River in the St. Paul area.[329] Finally, Mr. Gallant, also French Canadian, was the comptroller of the EGH.

In May 1939, the superior presented new plans to the Motherhouse and by August of that year, construction was finally approved.[330] However, the presentation of a new plans by the EGH superior may suggest that further cost reductions had been made. The exact amount could not be determined, but further evidence confirmed that the size of the building had been reduced since the new five storey wing, opened in 1940, included 100 beds as opposed to the original plan of 250.[331] Therefore, compromises had had to be made. Thus the EGH sisters did not obtain complete satisfaction. One hundred beds was better than none but a year after the opening of the new wing, the chronicles revealed that they were still short of space and that patients had to be refused.[332] Unfortunately, the war interrupted development plans and consequently nothing was done to remedy the situation until 1947.

---

[328] Ibid., 13 March 1939.

[329] More is said about these two men in the chapter on French Canada.

[330] ASGME, EGH, Chroniques, May and August 1939.

[331] ASGME, EHH, Doc. 195.

[332] ASGME, EGH, Chroniques, June 1941.

The temporary ward of 1948

In May 1947, physicians, under the leadership of Dr. John Orobko asked the sisters if it would not be possible to build a temporary 60 bed ward. The Motherhouse readily agreed, and as was the custom, a sister was named to supervise the construction. A year later the first patients were admitted to St.John's ward, named in honour of Dr Orobko.[333] These few beds were not expected to solve the problem and a new round of negotiations soon began.

The 1953 building and the end of the tuberculosis era

The addition of beds was again made necessary by the growth of Edmonton, but another reason made construction even more necessary. The province had started to build the Aberhart provincial sanatorium of Edmonton and its opening in the early 1950's would mean the transfer of all TB patients who were at the EGH to that institution. Considering that the space occupied by these patients was in the oldest building of the EGH the sisters believed that a new 200 bed facility had to be built in order to satisfy the needs of modern acute care. For the first time in the history of the EGH the sisters requested provincial assistance to build the new wing. Their decision was made on the basis of the new federal hospital construction grant program.[334] Other sign of the times: the physicians were delegated the responsibility to write to Premier Manning.[335] It could not be determined if Manning answered the letter, nor when the Motherhouse was first contacted about the project. What is known is that by May 1949, neither the province nor the Motherhouse had approved the project.

Significantly, Dr. L. P. Mousseau wrote to the superior general on May 7, 1949. Not surprisingly, his argumentation was based on factors resembling those used in 1938.

---

[333] Ibid., May and August 1947 and January 1948.

[334] Ibid., 8 September 1948; The hospital construction grant program, announced in Ottawa on May 8, 1948. The National Health Grants Act was designed to match the funding provided by provinces towards the construction of hospitals. Malcom G Taylor, ***Health insurance Canadian public policy, the seven decisions that created the Canadian health insurance system***, (Montreal: McGill University Press, 1978).

[335] ASGME, MMSM, 11 September, 1948.

However, much focus was put on the physicians' good will and religious allegiance:

> I want to bring to your attention that during the last ten years the hospital has had the best financial situation of its history ... In 1934, the hospital was almost a senior citizens' home while now it is an active centre with specialists in all fields. Physicians are united and have at heart the well being of the institution. Almost all young Catholic practitioners of all ethnic origins practice at the EGH. Five physicians are of Ukrainian or Slavic origin: Drs. Orobko, Sereda, Smulsky and Shandro represent the Ukrainians and Dr. Washanski the Polish. The Irish are represented by Drs Conroy and Foy, Dr. Bobe represents the Germans, and Drs. Fortier, Poirier, Rentier, Lefebvre, Allard and myself the French Canadians. The presence of all these men adds to the Catholic nature of our hospital. We need to build ... in 1934 there were 75,000 people in Edmonton, and now the population has reached 150,000 people.[336]

A few weeks later the Assistant General acknowledged receipt of his letter and wrote that the question was being studied.[337] However, in light of little concrete action, Dr. Mousseau paid a visit to the Motherhouse and obviously succeeded in influencing the General Council: "He had the talent to persuade the general council of the necessity to build in Edmonton. However, the ability to borrow remains an issue."[338] Notwithstanding that issue, three days later the sisters of Alberta received the authorization to select an architect.[339] Yet, it took another ten months to receive final approval.[340]

---

[336] ASGME, EHH, Doc. 195. Letter of Dr. L.P. Mousseau to the superior general Mother M.T. Courville of Montreal, Edmonton, 7 May 1949. Free translation.

[337] ASGME, EHH, Doc. 196, Letter of Sr. Sainte-Emilienne, assistant general to Dr. Mousseau, Montreal, 20 May 1949.

[338] ASGME, EHH, Doc. 197, Letter of Sister Fortier, assistant general of Montreal to Mother Vincent, superior of St. Albert, Montreal, 17 November 1949.

[339] ASGME, EGH, Chroniques, 21 November 1949.

It can be suggested that this long interlude was in large part due to ongoing attempts at convincing the new player in the era, the provincial government. The strategy to rally the province to the cause of the EGH included three groups of actors: the advisory board, the physicians and the sisters.

In July 1949, the advisory board promised to try to convince the province.[341] Although little is known about the actions taken by the members of the group, they probably used their social network to lobby Premier Manning. In September, Sister Herman (the superior), Sister Keegan (assistant to the superior), Dr. Mousseau and Dr. Orobko met with the Premier and were promised that the situation would be examined.[342] The same month the superior sought support from the city, and asked the Mayor for a contribution to the new building as well as an increase of the annual contribution.[343] It is apparent that the sisters attempted to find money from all possible sources and that they were relatively confident of success since in December an architect was selected.[344] However, by September 1950 the province had still not given an answer and the Superior and her assistant met with the provincial inspector of hospitals. In the chronicles it is reported that the assistant had accompanied the superior because the latter wished to have a witness. It is further stated that the inspector had been evasive and had suggested that the Grey Nuns should wait since two hospitals were currently being built in Edmonton and that the city might have a bed surplus.[345] In the light of this the Grey Nuns decided that immediate action had to be taken.[346] The fear of competition also convinced the General Council, which has stated earlier approved the construction the same month. However, in the increasingly bureaucratic world, planning took more time than in the past. The architects plans were approved only six months later, and sign of the changing realities, the Motherhouse sent a man to examine contractors' submissions.[347] On April 25, 1951 good news arrived and construction contracts were signed for a six floor building costing $1,654,888.12.[348]

---

[340] ASGME, EHH, Doc. 212, Telegram of Mother Courville to Sister Herman of the EGH, 16 September 1950.

[341] ASGME, EGH, Chroniques, July 1949.

[342] Ibid., 7 September 1949.

[343] Ibid., 20 September 1949. Data suggesting that the city provided assistance could not be found.

[344] Ibid., December 1949.

[345] These two hospitals were the Aberhart Sanatorium and the new Misericordia hospital.

However, money still had to be found and it appears that obtaining permission to borrow and locating funds for the EGH was linked to the ability to secure the same for a Montreal hospital. The author of a document received sometime after September 1951 indicated that the Vatican had given permission to borrow five million for the construction of the *Hôpital Maisonneuve* of Montreal and the building of a new wing at the EGH.[349] Because of the size of the loan, it is evident that the Grey Nuns had to seek approval from Rome. However, it is fair to suggest that if the EGH loan had been dealt with separately, approval might have been received more quickly since the sum was very small in comparison to the grand total. On the other hand, the EGH was only one of many Grey Nuns' institutions and it is logical that the General Council would have sought to group requests to the Vatican. Considering the even greater bureaucracy of Rome, it was probably wise to act in this manner.

Construction finally began sometime early in 1952 and the building was officially opened on May 1, 1953.[350] Approximately 200 beds had been added making the hospital a 434 bed facility. As stated the sisters had decided to go ahead even if provincial funding had not been not secured. As it turned out, in October 1952, they were given $406,000.00 by the province to cover approximately one third of the total cost. Interestingly, the chronicles revealed that the EGH was the first hospital in Edmonton to benefit from the federal grant program.[351] Considering that two other hospitals were built in the same era, it confirms that the Grey Nuns were resourceful administrators who knew how to capitalize on new programs. In closing, it is important to mention that the advisory board played another role related to the construction of that new wing. The board organized a "furniture campaign" through which $21,033.00 were raised for this purpose.[352]

---

[346] ASGME, EGH, Chroniques, September 1950.

[347] Ibid., 31 March 1951.

[348] ASGME, Chroniques, 25 April 1951.

[349] ASGME, EHH, Doc. 216, anonymous and no date. Date estimation deducted from the sequence of events.

[350] ASGME, EGH, Chroniques, 1 May 1953.

Hospital and health insurances

The first allusions to the idea of a national health insurance program were found in the minutes of the physicians' meeting of April 6, 1941. A physician, originally from Vienna, had been invited to share his views about the experience of his country where a federal health insurance program already existed.[353] His presentation was summarized in the minutes of the meeting:

> Poor people are without doubt benefited by the scheme. Its advantage to the medical men is chiefly to the recent graduate whose income is guaranteed during the lean years when doctors in ordinary practice are building up a practice [...] On the other hand the scheme necessitates a bureaucratic administration coming between the doctor and the patient which affects adversely the natural relationship of confidence between them [...] There results a definite undermining of moral and physical strength because of the encouraging of cultivation of sickness and magnification of minor complaints to secure benefits. At least one third of treatments given are unnecessary. Economic crises fill the waiting rooms of panels' doctors more than epidemics. Dishonesty of these doctors becomes a

---

[351] Ibid., October 1952.

[352] ASGME, EGH, Chroniques, January 1953.

[353] In light of WW II this physician must have been a Canadian resident since it is doubtful that a visitor would have been invited from Vienna in 1941.

> necessity if they are to survive.[354]

The reaction of the EGH physicians was not recorded, but the presentation included the type of arguments which were later used by the medical profession in opposing a national health insurance program. Indeed the effect on the sacrosanct physician/patient relationship was often used as a cause of concern and so was the fear that cost would rise by unjustified used of the system by the patients. In 1943, the CHAA also feared the prospect of hospital insurance. In particular, the organization was concerned about the ability to maintain the Catholic nature of its hospitals and about the degree to which ownership would be preserved.[355] The executive of the Association determined to be vigilant and to inform interested individuals. It is known that a special meeting was organized for Catholic nurses.[356] However, the nature of the meeting could not be established.

It appears that during the remaining war years, issues surrounding health insurance were set aside. However, after WWII, discussions about health insurance intensified and the development of a provincial hospital insurance plan in Saskatchewan in 1947 was a concern to the EGH sisters, who above all feared the loss of religious prerogatives.[357] To them the program was "alarmingly socialist".[358] Importantly, at the time most Canadians considered that socialism and communism were two sides of the same coin. This probably explains why the sisters feared for the Catholic nature of their hospital.

The provincial government of Alberta had reservations about the decisions that had been made by the Saskatchewan legislature. The Social Credit government was in fact opposed to universal coverage. However, because within a few months British

---

[354] ASGME, MMSM, Summary of Dr. Kurt Fuchs' address, 6 April 1941.

[355] Castonguay, ***A mission of caring***, 12.

[356] ASGME, EGH, Chroniques, January 1944.

[357] Ibid., January 1947.

[358] Ibid.

Columbia, the other neighbouring province, followed the example of Saskatchewan, the Alberta legislature was forced to consider the issue of hospital insurance. Indeed, public pressure was mounting since Albertans were well aware of developments in the adjacent provinces. In 1947, the AHA pushed for the introduction of a province-wide Blue Cross plan and support was obtained from the provincial legislature to incorporate the plan in 1948.[359] Hospital administrators were enthusiastic about Blue Cross because they believed that it would reduce administrative costs since through the elimination of all existing small plans, billing procedures would be made uniform.[360] They also believed that the plan could prevent the implementation of a "communist system" similar to the one created in Saskatchewan.[361] However, many could not afford to participate in the Blue Cross plan. In 1950, the province designed a special program for the recipients of social assistance and pushed municipalities to provide a form of coverage to their ratepayers and to introduce a voluntary plan for tenants who would become covered if they agreed to pay $10.00 a year.[362] This plan, known as the "dollar a day plan" ensured that participants could be hospitalized for the cost of one dollar per day of hospitalization. Under this scheme, the government contributed variable amounts of assistance depending on the age and the type of hospital. Municipalities had to pay the remaining portion of the cost.[363] This formula was acceptable for municipal hospitals but problematic for voluntary institutions. Municipal hospitals could count on their owner (the town or the city) to cover their operating costs. In concrete terms, this meant that the portion of hospitalization not covered by the patient and the province was absorbed by the municipal government. If hospitalization costs were rising, the city/town could increase municipal taxes accordingly, thus ensuring that sufficient funds were available to their hospital. Voluntary hospitals did not have the same privileges since the municipalities did not have to guarantee their survival. In other words, what was not paid by the patient or the province had to be almost entirely covered by these hospitals since the municipalities provided them with little assistance. Significantly, since voluntary hospitals could not levy taxes, their only source of additional funding was to raise patient fees. However, this could not be done either since patients would have turned to municipal hospitals for care offered at lower cost. Needless to say, the CHAA was alarmed by the situation. On September 25, 1951 the CHAA executive sent a letter to all Catholic priests summarizing the situation and asking them to attend a special emergency meeting in Edmonton or Calgary. [364] The purpose of this meeting was to provide further information to the priests who in turn would inform their parishioners. The arguments used by the CHAA were based on equity. Since Catholics citizens also paid taxes, they had the right to the same services as people from other denominations, and above all, they had the right to select the hospital where they would receive treatment. Consequently if the *status quo* was maintained and the province did not increase its funding, Catholics would lose their right to maintain their hospitals. It is evident that the situation was considered serious since the CHAA, which had feared that plans similar to those of Saskatchewan and British Columbia would be adopted, was by then reconsidering its views.

---

[359] ASGME, EGH, Chroniques, April 1948.

[360] Castonguay, ***A mission of caring***, 28; ASGME, EGH, Chroniques, November 1947.

[361] This rationale was provided by the president of the AHA who happened to be the collections agent of the EGH. ASGME, EGH, Chroniques, November 1947.

[362] Malcom G. Taylor, ***Health insurance and Canadian public policy. The seven decisions that created the Canadian health insurance system***, (Montreal: McGill-Queens University Press, 1978), 169; Donald Juzwishin, "A history of the Alberta Hospital Association, 1919-1970," (Health Services Administration, Master's thesis, University of Alberta, 1985), 76: Brown, "The evolution of hospital funding in Alberta," 54.

[363] Taylor, ***Health insurance and Canadian public policy***, 169.

> If this plan is effective in putting a large number of voluntary hospital beds out of business, it would seem to be a much more destructive plan than that of Saskatchewan or British Columbia. Hospitals of all denominations are treated

---

[364] Castonguay, ***A mission of caring***, CHAA executive meeting of 1951, 35.

> with equal rights in these two provinces.[365]

The ensuing campaign must have been fairly successful, since in 1952 the government increased the funding it provided to hospitals.[366] However, until 1958 the province continued to implement changes in a patchwork manner, each time threatening the survival of voluntary hospitals. On July 1, 1953 a new formula was adopted to cover pharmacy, laboratory, radiology, and surgical costs. These services were labelled "hospitalization extras" and under the scheme the hospitals were provided with a maximum of $4.00 for extras. The patient was to pay $1.00 and the city and the province $1.50 each.[367] These amounts did not cover the actual costs and once again voluntary hospitals were caught between a rock and a hard place. In 1953, the Chairman of the medical executive committee of the EGH summarized the situation in these words:

> There is no need of going into the details [of the "hospitalization extra" legislation] however, this legislation is an example of what our present government does irrespective of future consequences and repercussions. The profession and the non-government hospitals must demand more liaison, and at least have some say regarding future legislation.[368]

This time it appears that the government stood firm on the issue and that change did not occur until new legislation was introduced in 1958.

World War II

On September 3, 1939, Britain and France declared war on Germany, and a week later Canada became engaged in the conflict.[369] Canadians from all parts of the country immediately enlisted. During the five years of war, 78,000 men and 4,500 women in

---

[365] This information was enclosed in the letter sent to Catholic priests. Ibid.

[366] Ibid., 41.

[367] ASGME, EGH, Chroniques, 25 June 1953.

[368] ASGME, MMSM, Annual report of Dr. Shandro, December 1953.

[369] Trofimenkoff, ***Visions nationales***, 336.

Alberta joined the forces.[370] At least 170 of the women were nurses, 12 of whom were graduates from the EGH.[371]

Little information was found about the effect of WWII on the EGH. In particular, the chronicles contained a relatively small number of statements on the topic. Seven of these entries were about special prayers for peace, four about staffing problems, three about American soldiers, two about soldiers' admissions to the EGH, and one about the end of the war.[372]

In Edmonton, the war created new employment opportunities. In particular, the city played an important role in the Commonwealth Air Training Plan and almost overnight the local airfield (Blatchford Field) became one of the busiest airports on the continent.[373] The pilot training program was not the only reason why Edmonton played a central role. In 1940, the United States, fearing a Japanese invasion of Alaska, engaged in a large airlift operation aimed at building up Alaska's defense. Because of its strategic location, the Edmonton airport became an important relay centre. However, this was only the beginning of American presence in the area. The attack on Pearl Harbor on December 7, 1941 marked the official entry of the United States into WWII, and this event made real the fear that Alaska might be the next target of the enemy. On February 14, 1942, the American forces decided to build a road that would link the remote state to the rest of the continent, and two days later, Americans obtained Ottawa's permission to build 1,121 miles of highway on Canadian soil.[374]

---

[370] Palmer and Palmer, ***Alberta a new history***, 282.

[371] Cashman, ***Heritage of service***, 229-230; It has been estimated that 3,649 Canadian nurses joined the armed forces during World War II. Gibbon and Mathewson, ***Three centuries of Canadian nursing***, 456.

[372] ASGME, EGH, Chroniques, 1939 to 1945. Staffing issues are addressed in the chapter on the EGH workforce.

[373] On September 23, 1943, 860 planes landed in Edmonton. MacGregor, ***Edmonton, A history***, 263-265.

[374] Ibid.

Within weeks, 10,000 troops and 17,000 civilians engaged in the highway construction and hundreds of Americans made their homes and headquarters in the city of Edmonton.[375] The presence of so many service men did not please all Edmontonians, but generally the soldiers were welcomed and integrated themselves into the local community.[376] Significantly, the chronicles contained a number of statements that were directly related to the presence of American soldiers. In 1942, the EGH was requested by the Canadian forces to keep beds open for the use of American soldiers.[377] There is evidence that during the following months, American soldiers were admitted to the hospital. For example, the chronicles of December 1942 revealed that 15 of them were using the facility. It seems that the Americans were grateful for the services received at the EGH. An example of their gratitude took place in January of 1945 when they offered the sisters to show a movie at the hospital. The chronicles stated: "Our good friends the American soldiers came to show us a movie entitled *Going My Way*. Approximately 100 sisters of other orders of Edmonton also came to the presentation."[378] The soldiers also participated in Christmas activities. In December 1943 the American troops distributed candies, nuts, and toys to the patients of the tuberculosis service.[379] Interestingly, the EGH chronicles hardly mentioned Canadian soldiers. The absence of entries about them is probably related to the fact that during the war years, the Canadian Armed Forces purchased the local Jesuit college and transformed it into a military hospital. Thus, it is unlikely that many Canadian soldiers were admitted to EGH.

---

[375] Ibid., 264; Palmer and Palmer estimated that 1,400 Americans lived in Edmonton in 1942. Palmer and Palmer, ***Alberta a new history***, 284.

[376] MacGregor, ***Edmonton, A history***, 263-265.

[377] ASGME, EGH, Chroniques, June 1942.

[378] Free translation. ASGME, EGH, Chroniques, January 1945.

[379] Ibid., December, 1943.

Sources of financial support

It is likely that between 1938 and 1957 the EGH increasingly relied on provincial funding. Until 1952, the operation of the tuberculosis service provided regular provincial income which facilitated the planning of overall hospital operations. As shown, the period was characterized by the adoption of a variety of insurance plans which on the whole increased the participation of the province in the day to day operation of hospitals. Consequently, it may be stated that in the 1950's the hospital entered in a new era in which public funding was becoming the most important source of revenue, while direct financial participation of patients was gradually decreasing. Finally, it is important to mention that for the first time the federal government contributed a substantial amount of money through its hospital construction plan.

Hospital budgets

Budgets of the era were not available. However, the 1953 hospital expenses records were preserved. In 1935-1936 when the hospital had approximately 200 beds it spent $88,936.55 (see Table 14). In contrast, by 1953 when the bed capacity had increased to 434 beds, expenses totalled $1,424,650.86 (see Table 15). It can be seen from these figures that, although the number of beds only doubled, costs were 16 times greater. Some of that increase can be accounted for by inflation. However, closer examination of the results presented in Tables 14 and 15 show that salaries comprised 26.61% of the expenses in 1935-1936 while they had risen to comprise 53.03% of the 1953 expenses. This increase in the proportion of money spent on salaries can be attributed to the fact that the EGH had become a major employer of nurses and other health care personnel. Gone were the days when a few sisters assisted by an army of students could provide all patient care.[380] Considering that variations among other variables were much more marginal, the magnitude of this change is even further apparent. As a whole, the results presented in Table 15 show the extent to which operating a hospital had become a major venture. They suggest that accounting procedures and operational planning necessarily had to be far more complex than in earlier years.

---

[380] See the chapter on the EGH workforce for more details about the growth of this workforce.

TABLE 15

EXPENSES IN 1953[381]

Source of expense	Amount (%)
Construction/renovation	$36,553.21 (2.56)
Depreciation	$97,173.39 (6.82)
Food	$154,252.08 (10.83)
Insurances *	$14,989.60 (1.05)
Interests	$122,422.34 (8.59)
Legal fees	$592.50 (0.04)
Salaries	$755,546.37 (53.03)
School	$12,399.88 (0.87)
Supplies	$190,034.62 (13.34)
Utilities	$32,133.51 (2.26)
Taxes	$4,282.55 (0.30)
Others	$4,270.81 (0.30)
Total	$1,424,650.86 (100.00)

* Included contribution towards employees insurance plan and the provincial work compensation board: $7,049.49 of total cost.

In summary, the period from 1939 to 1957 brought significant changes to the EGH. The hospital doubled its bed capacity, it served as a sanitorium for a number of years and, although the sisters maintained their power and authority, it became evident toward the end of this era that they would have to increasingly rely on lay administrative personnel. Indeed, the events of the next decade show that the sisters came to the conclusion that they would have to delegate most of their authority to lay administrators.

---

[381] ASGME, Hôpital Général finances - 1950 to 1958, 1953 expenses.

CHAPTER 10

THE HEALTH INSURANCE ERA: 1958-1970

In Canada, the period between 1958 to 1970 was marked by general prosperity and optimism. Significantly, during these years, the federal government successfully established national health care policies. This was a major accomplishment considering that the central government had to convince each of the ten provinces to engage in the national hospital insurance plan, even though under the constitutional law the provinces are responsible for health care services. Two major federal health care policies were adopted between 1957 and 1968. In 1957, the House of Commons adopted the Hospital Insurance and Diagnostic Services Act. Although provincial participation was voluntary, none of the provincial governments could resist the federal offer of a 50%/50% cost sharing arrangement. Consequently, by 1961 all provinces had accepted the terms of the act which stipulated that in order to receive federal funding, provinces had to offer "... universal coverage, portability of coverage from province to province, comprehensive coverage for all in-hospital care in general and certain other designated care, and public, nonprofit administration of plans was mandatory."[382] In 1968, after years of resistance from the medical profession, the federal Medical Care Act was proclaimed and within three years all provinces had agreed to participate. Under the terms of this act, medical services became ensured in the same fashion as were the hospital services.[383]

Administrative structure

The administrative structure of the hospital was significantly modified during the 13 years under study. A letter written in 1963 revealed that the Grey Nuns had been recruiting for the new position of executive director. Sister Laporte wrote that recruiting for this position had become necessary because of the increasing complexity of hospital administration, because of the difficulties of finding sisters who were sufficiently prepared for the role, and because it was believed that having a lay administrator would facilitate communication with the provincial government.[384] Evidence suggests that the province was pressuring Catholic hospitals to change their administrative structures. Mr. Aman, the Assistant-Administrator of the EGH wrote:

---

[382] Janet Ross Kerr, "The organization and financing of health care: Issues for nursing," In ***Canadian nursing issues and perspectives***, 2d ed., ed. Janet Ross Kerr and Jannetta MacPhail, (Toronto: Mosby Year Book, 1991), 172.

[383] Ibid.

> The provincial government gives the impression that they would prefer to have Catholic Hospitals removed from the Health Field. I feel however, that this is not the situation. I believe that they wish to have the Sisters continue to own and control their operations in the field. The true problem appears to be a more subtle one. They apparently wish to separate the Sisters' Communities from actual Hospital Operation as well as have lay people given some say in the senior management function.[385]

However, it appears that the sisters decided not to act hastily, and to make changes which would facilitate the establishment of the position of executive director while ensuring that they would continue to oversee the destiny of their hospital. Some time in 1968, a Board of Directors was created and changes were made to the corporate structure of the hospital. In essence, the role of President of the Corporation was transferred from the EGH Superior to the Provincial Superior.[386] This measure was important because it ensured that the removal of the hospital superior would not mean the end of the Grey Nun's authority. Two months later, Mr G. Pickering, became the first Executive

---

[384] ASGME, EGH, Board of Directors correspondence, Letter of Sister Jeanne Laporte to Mother Dorais, Superior General, 27 December 1963.

[385] ASGME, EGH, Correspondence of Assistant-Administrator - 1964-1967, Letter of Mr. Aman, Assistant-Administrator to Sister Thérèse Chaloux, Superior and Administrator, October 5 1964.

[386] ASGME, EGH, MMSM, Letter of Sister Prevost, Provincial Secretary to Mr. Aman, Assistant-Administrator of the EGH, 10 March 1968; Until 1959, the EGH was part of the Grey Nuns general corporative act, in 1959 a separate act of incorporation was assented to by the provincial government. The President of the corporation was also the President of the Hospital Board of Directors, which included seven positions which were all filled by seven Grey Nuns who delegated their authority to lay employees. Ell, "Edmonton General", 82-83.

Director of the EGH.[387] A new era had begun and further changes were made to the hospital administrative structure. Of significance, the Superior had always been in charge of the hospital and of the sisters' community. The hiring of an Executive Director made necessary the creation of a position of Community Superior whose role did not include any hospital responsibilities. It may thus be suggested that the sisters responded to the province's request of separating religious and hospital matters. However, the fact that the Provincial Superior was also President of the Hospital Corporation ensured that religion and hospital were not entirely separated.

Of importance, a Board of Governors was created on October 8, 1970.[388] Sister Fernande Dussault, Provincial Superior, attended the first meeting and stated:

> The Board [of management] has been created for many reasons, the most important being: a) the ever growing complexity of hospital operations as a result of advances in science and technology; b) the increasing complexity in hospital financing; c) the need to involve residents of Edmonton in the operation of the hospital and to ensure that the hospital reflects the views of the community it serves.
>
> The Corporation [Grey Nuns Corporation] will naturally continue to take the same interest in the hospital as it always has and it will not want anyone to think that setting up the Board of Management means any lessening of interest in the operation of the Edmonton General Hospital.
>
> In selecting members for the Board of Management, the Corporation has appointed persons with backgrounds in hospital administration, medicine, nursing, education, and business in order to provide a combination of talent and experience to deal with the complex problems which arise in the operation of a hospital.
>
> Aside from the powers retained by the Corporation, the Board of Management is charged with the overall responsibility of administering the hospital. Your task

---

[387] ASGME, EGH, Chroniques, 2 July 1968.

[388] This Board replaced the Board of Directors.

> is not an easy one, and is made more difficult by the fact that whereas many hospitals have a tax-base support, the EGH does not enjoy this type of support. This means that the hospital must be administered more economically in order to provide a standard of science comparable to such hospitals without incurring deficit.[389]

It is important to note that the Corporation considered that a nursing presence on the new Board of Management was essential. This lends support to the view that the sisters recognized the importance of the nursing care services of the hospital.

Administrative issues

Aside from the administrative restructuring of the hospital, three issues took centre stage during this period of time: the increased participation of the state in hospital matters, the equity question, and the destiny of the School of Nursing.[390]

The increased participation of the state

The emergence of the provincial hospital insurance plan in April, 1958 significantly modified the relationship between hospitals and the province. This was particularly salient for Catholic Hospitals which until then had almost complete autonomy. Hospital administrators had to adjust to the need to request provincial government permission on a number of issues which until then had been dealt independently. For example, in 1964 when the EGH Superior decided that the time had come to build a new hospital wing, she had to seek provincial approval.[391] Similarly, the hospital rationale for all expenses had to be provided to a much greater degree than in the past. For example, the government was concerned about the salaries of the sisters who worked in Catholic Hospitals. Following the publication of a salary survey in 1959 by the provincial department of health, the government began to argue that the sisters were better paid than lay employees who were in similar categories of employment. The CHAA responded and explained that the sisters usually had more seniority, more experience and more education than lay employees. The CHAA lost this battle and the sisters salaries were thus reduced.[392] One has to wonder if the outcome would have been the same if the sisters had been men instead of women. Considering the chronic inequities in matters of salary, it is likely that if they had been priests or brothers instead of nuns, their salaries would not have been reduced.

---

[389] ASGME, EGH, Board of Management, Minutes of the first meeting of the Board, 8 October 1970.

[390] The destiny of the School of Nursing is addressed at the end of the chapter devoted to the school.

[391] ASGME, EGH, Chroniques, October 1964; A new wing of 90 beds was opened in 1967.

Sisters' Equity

One of the most important questions which arose after the adoption of the provincial hospital insurance plan related to the fact that Catholic Hospitals were privately owned. However, under the new law they could not make any profit. Thus a formula had to be established in order to recognize that the communities had invested enormous amounts in their institutions, that means of paying debts had to be established and that if the orders decided to sell they would be guaranteed a fair price for their properties and physical plants. This issue required intense negotiation involving the CHAA, the AHA and the government. Fortunately, the government responded in a fair manner and most Catholic Hospitals accepted its offer.[393]

Sources of financial support and hospital budgets

During the 1960's, the provincial and federal governments became the almost exclusive source of financial support, since patients no longer paid for services. The hospital continued to request assistance from the city of Edmonton, but as in previous years, municipal funding remained difficult to obtain.[394] Although yearly budgets were not available, it is known that the hospital incurred deficits in 1967 and 1968, and that these were considered to be related to the construction of the new wing and to salary increases.[395] The lack of an equity clause at the time probably contributed to these financial problems as well as the rising utilization of a number of hospital services, such as radiology and laboratory.[396]

---

[392] Castonguay, ***A mission of caring***, 54-55.

[393] The EGH signed a settlement on 31 December 1969. ASGME, EGH, Edmonton Hospital Corporation Sisters Equity 1968-1972, agreement between the EGH corporation and the province of Alberta, 31 December 1969.

[394] Evidence of requests were found in the Board of Directors' correspondence of 1968 to 1970.

In conclusion, this period was marked by radical change since the hospital administrative structure was almost entirely modified. For the first time in the history of the EGH, a lay administrator was given charge of the institution, while at the same time much of the freedom of the past was replaced by state involvement. There is no doubt that provincial hospital and medical insurance plans were good for the citizens. However, it may be suggested that adapting to the new system was not an easy task for the Sisters of Catholic Hospitals who until then had been sole mistresses in their house.

---

[395] ASGME, EGH, Minutes of the Board of Directors, 1967 to 1969.

[396] This topic is further addressed in the chapter devoted to patient care.

CHAPTER 11

THE GREY NUNS - WHO WERE THEY?

As the founders and owners of the Edmonton General Hospital, the Grey Nuns played a central role in the development and daily life of the hospital. Members of the Order were present in most spheres of activity and as a group the Sisters assured the continued functioning of the hospital. The purpose in this chapter is to shed light on the background and demographic characteristics of the Grey Nuns whose principal objectives were central to the EGH during the period of time under investigation. Examining the cultural and social background from which the nuns came is useful because it can contribute to a better understanding of the forces which shaped the institution and the principles which characterized it over time. The results of this analysis show that the typical sister came from a Quebec rural area, grew up on a farm, was one among many siblings of a large French Canadian family, had a number of relatives who were members of religious orders and was a graduate of a Grey Nuns' school of nursing.

The data presented in this chapter has been extracted from information recorded in the personal files of the sisters who worked at the EGH and which are housed in the Grey Nuns Archives of the province of Alberta. Access was secured for use of the demographic content of these files in order to prepare a profile of the nuns who operated the hospital and directed the nursing services. Other information enclosed in these files was not consulted, since that information was judged by the Grey Nuns' Archivist to be of private nature since a number of sisters whose files were consulted are alive. The data was therefore treated as confidential and private material. For similar reasons it was judged necessary to ensure anonymity of each file. This was done by assigning a numerical code for each subject of the sample.

The population of sisters who had worked at the EGH between 1895 and 1970 was identified from a list made by the Order in 1988.[397] This list revealed that 222 sisters worked at this institution during the period of time under investigation. Of the total of 222, it was possible to obtain information on 209 sisters; there was thus thirteen missing cases. The demographic data extracted from these files included place and year of birth, year of death, nationality, educational level, occupation, list of siblings, list of relatives belonging to religious orders, and father's occupation. It was also possible to identify the schools of nursing from which those in the sample of nurses graduated, as well as institutions at which further education was acquired.

---

[397] ASGME, EGH, Liste des Soeurs qui ont missionné à l'Hôpital Général d'Edmonton de 1895 à 1988.

Place of birth

Results presented in Table 16 show that 121 sisters, almost 58% of the sample, were born in the province of Quebec. A number of reasons can be suggested to explain why such a large number of sisters came from that province. In the first place, the Grey Nuns' Order originated in Quebec and the Motherhouse was and continues to be located in Montreal. As the province with the largest Roman Catholic population in Canada and with the second largest provincial population, it is logical to find the largest number of members of religious orders in that province. In addition, some years during the period of time studied correspond to the period which stands out beyond all others in terms of the large numbers of women joining religious orders in Quebec. Only fifty-one sisters originated from the rest of Canada representing 24.40% of the sample.

It is of interest to note that the number of sisters born in the United States surpassed the number of sisters born in Alberta, these sisters forming almost 12% of the sample. Of the 25 sisters who came from the United States, 19 were born in the New England area. Twelve sisters were from Massachusetts, two from Maine and New York, while New Hampshire, New Jersey and Rhode Island each were the birthplace of one sister. Four of the remaining sisters came from Ohio and one from Minnesota.[398] The preponderance of New England as area of origin is consistent with French Canadian emigration patterns of the end of the 19th century. Data on father's occupation and reported nationality confirm this as it can be seen that more than half of the sisters from this part of the United States were first generation Franco-Americans whose families had migrated to industrialized regions of the Northeastern United States.

---

[398] State of birth not known for one sister of American origin.

TABLE 16

PLACE OF BIRTH OF THE GREY NUNS WHO WORKED AT THE EGH

Place of birth	n	%
Quebec	121	57.89
Alberta	19	9.09
Saskatchewan	13	6.22
Ontario	6	2.87
N.B.	6	2.87
Manitoba [399]	5	2.39
N.S.	1	0.48
P.E.I.	1	0.48
United States	25	11.96
France	4	1.91
England	2	0.96
Ireland	1	0.48
Switzerland	1	0.48
Unknown	4	1.91

Alberta was the second most common province of origin of nuns who worked at the EGH. The 19 sisters born in this province comprised 9.09% of the sample. These sisters were born between 1896 and 1932. The places of origin in this province and the number of sisters who were born in these locations are presented in Table 17. These results show that all sites but two, Calgary and Hilliard, were common places of origin for Franco Albertans. In fact, most of the communities of origin included here had first been settled by French Canadians and were considered at the time as "French places".

---

[399] There was conflicting evidence about the origin of one sister who at time was listed as being from Manitoba and at other times from Newfoundland. The Manitoba origin is used in this study.

Results presented elsewhere show that in fact 16 of the 19 Albertan sisters were French Canadians.

TABLE 17

PLACES OF ORIGIN OF THE SISTERS BORN IN ALBERTA

Places of origin	n	Total
Lamoureux, Legal and St. Paul	3	9
Calgary and St. Albert	2	4
Beaumont, Chauvin, Edmonton, Hilliard, Morinville and St. Vincent	1	6

The first reviewed of the raw data, caused surprise because of the small number of sisters born in Alberta. However, considering this number at face value and comparing to the number of sisters from other places might be somewhat misleading. In fact, 19 might have been a relatively large number of sisters. To come to this conclusion, one must considerer similar factors as those mentioned about Quebec as a place of origin. For example, the characteristics of the population of Alberta and the tradition of geographical mobility in the Grey Nuns' Order are relevant. Although statistics on religious vocations in Alberta for the period of time under study could not be found, considering that the Roman Catholic religion was not the predominant religion in Alberta for most of the years under study it seems reasonable to conclude that the number of sisters joining the Order would have been lower than in Quebec where the majority of the population was Roman Catholic. Data presented below show that the great majority of the sisters from both provinces were of French Canadian origin. This is what might be expected since the Grey Nuns' Order primarily attracted women from that ethnic group. Considering the small proportion of French Canadians in Alberta, 16 sisters might indeed be a large number. In addition, this figure should not be considered as necessarily representative of the number of Franco-Albertans who joined the Order. The geographical mobility of the sisters must be considered. All sisters spent some time at the Mother House in Montreal where perpetual vows were taken and where initial assignments of sisters to geographical locations were often attributed. Thus the sisters born in Alberta did not necessarily work in Alberta, let alone at the EGH.

More general sociological factors must also be examined especially for the earlier years covered in this study. It is highly probable that vocation numbers of young women joining the Order might have been limited during the settlement period. Survival considerations linked to the development of a new farm might have made the presence of daughters more essential to the family economy than in more developed regions of the country. Physical labour provided by all who were able was needed to open land to agriculture. The association between religious vocation and the presence of role models is also of importance. A large proportion of the sisters in this study had aunts or uncles who had chosen religious life. When a family settled in Alberta, it often meant that children did not have regular contact with uncles and aunts who might have served as role models[400]. Role modelling provided by Grey Nuns in a given community was also an important factor in encouraging women to decide to join the Order. The results of this study reinforce this point.

Nationality

It was possible to determine the nationality of 208 subjects. Information about ethnic origins and about various relationships concerning nationality and place of origin is presented in Tables 18 through 22. Eight ethnic origins were identified: American, English, French Canadian, German, Italian, Irish, Metis and Polish. For the purpose of this analysis, the French Canadian nationality also includes Franco-American and French sisters. The term French Canadian was selected because most sisters of French origin (in the widest sense) used it to define themselves, and because French Canadian *per se* were the most common subjects. It was also noted that some of the Franco Americans sisters labelled themselves as French Canadians. The American category is comprised of individuals born in the USA who were identified as Americans in their biographical records, and for whom their exact ethnic origin could not be determined. Members of the other nationalities represented in this sample were born in the mother country of their ethnic group, in Canada or in the United States.

---

[400] The question of the role modelling played by family members is addressed elsewhere.

TABLE 18

NUMBER AND PERCENTAGE OF SISTERS BY NATIONALITY

Nationality	n	%
French Canadian	181	86.60
Irish	9	4.31
German	6	2.87
English	5	2.39
American	3	1.44
Polish	2	0.95
Italian	1	0.48
Metis	1	0.48
Unknown	1	0.48
TOTAL	209	100.00

Results presented in Table 18 show that 181 sisters were French Canadian and that they represented 86.60% of the population studied. Excluding the one sister for whom the nationality could not be identified, all other nationalities comprised only 12.92% of the total group. Although this represents a small percentage of the total number of sisters, the origins of these sisters are meaningful because they reflect representative ethnic groups contributing to the fabric of Alberta.

As stated, French Canadians were far more numerous than any other group. The number and percentage of French Canadians by place of origin is presented in Table 19. Not surprisingly, 118 of these sisters came from Quebec and they represented 65.19% of the French Canadian sisters. These sisters formed also 97.52% of the Quebec cohort (see Table 21). Alberta was the second most important place of origin for French Canadian sisters. Considered only by place of origin, the American sisters were the second most important group and Albertans the third. When French Canadian nationality is included these ranks are reversed. Sixteen French Canadian sisters came from Alberta, constituting 8.84% of this ethnic group and comprising 84.21% of those sisters (see Tables 19 and 21). Fourteen sisters were Franco-American comprising 7.73% of the French Canadian Sisters and 56.00% of the United States' group. It is of interest to note that the families of at least three of the American sisters returned to Canada (two to Quebec and one to Alberta).

TABLE 19

NUMBER AND PERCENTAGE OF FRENCH CANADIANS BY PLACE OF ORIGIN

Place of origin	n	%
Quebec	118	65.19
Alberta	16	8.84
Saskatchewan	10	5.52
N.B.	6	3.31
Ontario	6	3.31
Manitoba	5	2.76
P.E.I.	1	0.55
United States	14	7.73
France	4	2.21
Unknown	1	0.55
TOTAL	181	100.00

French Canadian sisters born in Saskatchewan constituted a relatively large group as well. The presence of the Grey Nuns in that province and the proximity to Alberta might explain why 10 French Canadian sisters came from Saskatchewan. As well, French Canadian sisters came from four other provinces. Their total numbers were eighteen (see Table 19). Of interest is that for each of these provinces they represented 100.00% of the total sample of sisters born there (see Table 21). The origin of three of the four sisters from France reveals a great deal. Two of them were from Brittany and had travelled to Canada with Oblate priests, while a third had a cousin who also belonged to that religious order. The majority of the Oblate priests were from Brittany, and it is believed that their long collaboration with the Grey Nuns in western Canada may explain the choice made by these three sisters who came from the same area of France. The fourth sister from France came to Canada as an adult. Her mother and some of her siblings had already immigrated to this part of the country.

TABLE 20

NUMBER AND PERCENTAGE OF SISTERS FROM OTHER NATIONALITIES THAN FRENCH CANADIAN BY PLACE OF ORIGIN

Place of origin	n	%
Alberta	3	11.1
Quebec	3	11.1
Saskatchewan	3	11.1
N.S.	1	3.7
United States	11	40.7
England	2	7.4
Ireland	1	3.7
Switzerland	1	3.7
Unknown	2	7.4
TOTAL	27	100.0

TABLE 21

NUMBER OF FRENCH CANADIAN SISTERS (FC) AND OF SISTERS OF OTHER NATIONALITIES (O) AND PERCENTAGE EACH GROUP REPRESENTS FOR EACH PLACE OF ORIGIN

Place of origin		n of FC	%		n of O	%		Total
Quebec		118	97.52		3	2.48		121
Alberta		16	84.21		3	15.79		19
Saskatchewan		10	76.92		3	23.08		13
N.B.		6	100.00		--	---		6
Ontario		6	100.00		--	---		6
Manitoba		5	100.00		--	---		5
P.E.I.		1	100.00		--	---		1
N.S.		--	---		1	100.00		1
United States		14	56.00		11	44.00		25
France		4	100.00		--	---		4
England		--	---		2	100.00		2
Ireland		--	---		1	100.00		1
Switzerland		--	---		1	100.00		1
Unknown		1	33.33		2	66.67		3
Totals		181	87.02		27	12.98		208

* One missing subject for whom nationality and place of origin are not known.

TABLE 22

PLACES OF ORIGIN BY NATIONALITIES OTHER THAN FRENCH CANADIAN

Place of origin	Nationalities							
	AM	EN	GE	IR	IT	ME	PO	Total
United States	3		4	4				11
Alberta					1		2	3
Saskatchewan		1	1			1		3
Quebec		1		2				3
England		1		1				2
Ireland				1				1
Nova Scotia		1						1
Switzerland			1					1
Unknown		1		1				2
TOTAL	3	5	6	9	1	1	2	27

Abbreviations used: American (AM), English (EN), German (GE), Italian (IT), Irish (IR), Metis (ME), and Polish (PO).

As stated, 12.92% or 27 sisters were not French Canadian. When not broken down by ethnic group, it is striking to see that 11 of these sisters came from the United States (see Table 20). They represented 40.70% of the sisters from a nationality other than French Canadian. There were also never more than three sisters from any one of all other places of origin (see Tables 20 and 21). It is likely that this great representation of sisters born in the United States can be in large part explained by the presence of the Grey Nuns in their states and towns of origin. The twenty-seven sisters of a nationality other than French Canadian were from seven ethnic groups (see Table 22). Only three of these groups included five or more sisters who worked at the EGH. Sisters of Irish origin formed the largest group. Nine sisters were Irish and they constituted 4.31% of the total sample and 33.33% of the sisters of a nationality other than French Canadian (see Table 18). Six sisters were from German origin, four of whom were from the United States (see Table 18 and 22). These sisters were all from Toledo and the data revealed that they came from the St. Mary's Parish, a German parish where the Sisters of Notre-Dame of Naumur were teachers. Toledo had a hospital operated by the Grey Nuns and the demographic file of one of the sisters indicated that at age 14 she had started working at that hospital. She arrived at the EGH in 1898 where she received her nursing education and continued to work for a number of years. The presence of Grey Nuns in Toledo undoubtedly explains in large part why these women decided to join the Order. Why these four sisters were sent to Edmonton is not known; however, language may have been a factor. German immigrants were numerous in the area and it may have been advantageous for a hospital to have sisters who could speak their language, especially since competition for patients was strong between the various hospitals of Edmonton. The five sisters of English origin came from a variety of locations and one of them was the only member of the group from Nova-Scotia.

Thus, the sisters who worked at the EGH came from many provinces and countries and from different cultural backgrounds. Sisters from Quebec were the most numerous as were French Canadians. Most of the other nationalities represented in this study were usually fertile ground for the Roman Catholic Church. It is significant that the sisters of this study often grew up in areas where the Grey Nuns were well established. Finally, one of the most surprising results was the large representation of sisters born in Northeastern United States.

Parental occupation

Information about parental occupation sheds further light on the sisters' backgrounds. The organization of the data collected on parental occupation was done by category. However, the use of existing occupational scales did not seem to be appropriate, because these are usually established from the census of a given year and thus represent only the occupational structure of that year.[401] Interpretations are thus difficult at best, and the further the time lapse from that census year, the greater the risk of misinterpreting raw data on occupations. Because of the long period of time covered in this investigation, the use of an existing scale would have been problematic. The time element also meant that as the years passed, some occupations disappeared while others were created. The occupational scale which was designed for use in this study for analyzing fathers' occupations has limitations. Results presented should be interpreted with caution and generalizations cannot be made about the degree of wealth of the families in the group. Family income is unknown and the level of income associated with a given occupation varies considerably over time as well as within that occupation. The geographical distribution and varied nationalities of the families in the sample analyzed must also be taken into account. The degree of prestige associated with an occupation is often conditioned by these characteristics.

Occupation of mothers

Maternal occupation was specified for only six subjects, all of whom were from Quebec. This is not surprising considering that the 209 sisters of this study were born between 1842 and 1938. During this period of time, few married women worked outside their homes, and work within the home, such as work on the family farm, was not valued as work in the same way as it was for men in the group. Because two of the sisters for whom the mother's occupation is known were siblings, the occupations of five mothers were in fact known. Three of these were school teachers, one was a seamstress and one performed as a miller.[402] The occupation of the husbands of four of these women is known. One of the teachers was married to an organ carpenter. Her father, Mr. Casavant had the same occupation and owned a company whose name was internationally renowned for the quality of the organs it produced. The seamstress, the miller and one of the teachers were all married to farmers. In that the occupation of the husband of the third teacher was not indicated, it is possible that this mother might have been a widow.

---

[401] Bernard B. Blishen, "The construction and use of an occupational class scale." ***The Canadian Journal of Economics and Political Science*, *18***(4), 1958: 522.

[402] The miller was the mother of two of the sisters for whom a mother's occupation was specified. She was also the grandmother of a third Grey Nun included in this study.

Occupation of fathers

There were 162 subjects for whom it was possible to determine paternal occupation. Eighty-four of these fathers were farmers, while the remaining 78 men were engaged in a total of 35 other occupations. Twenty-six of these occupations were assigned to three larger occupational groups: sales-related, professions and trades. The remaining nine occupations were classified as "other". Sixteen occupations were classified as trades: blacksmith, breadmaker, bricklayer, carpenter, edgesetter, electrician, fisherman, labourer, lumber mill worker, machine worker, mechanic, minor, railroad construction worker, shoemaker, stone-cutter, and typesetter. Although the degree of skill required in these occupations is variable, it was decided to include them in the same category since they all involved primarily manual labour. Included in the sales category were the following five occupations: contractor, grain agent, Hudson Bay Company clerk, manager and merchant. The professional category included five occupations; these were: engineer, pharmacist, lieutenant governor and teacher. The remaining nine classified as "other" were: artist, church inspector, decorator, foreman, policeman, registrar, person of private means, stockbroker, and usher.

The total number and percentage of fathers in each occupational group is shown in Table 23. The 84 fathers who were farmers comprised 51.85% of the sample, while 42 fathers or 25.92% of the subjects earned their living in various trades. These two occupational groups included 77.77% of the fathers. Thus, more than three quarters of the sisters came from families which were likely of relatively modest means. Twelve fathers pursued occupations which could not be classified in the first two groups and some of these may have earned higher incomes. In general, it is likely that most of the latter occupations would have lead to lower middle range incomes. Finally, only five fathers were members of professions, out of which only one could have been classified as a high income earner.

TABLE 23

TOTAL NUMBER AND PERCENTAGES OF FATHERS IN EACH OCCUPATIONAL GROUP

Occupational Group	n	%
Farming	84	51.85
Trade	42	25.92
Sales	19	11.73
Other	12	7.41
Profession	5	3.09
TOTAL	162	100.00

Excluding the five professional fathers it seems reasonable to suggest that most fathers would have had little education beyond elementary school. However, in the context of the time period being studied, only a relatively small number of people achieved higher than elementary level of schooling. The fathers in this sample were probably not more poorly educated than the average man in the population. Their occupations were probably also typical for the times. The hypothesis that the fathers of the sisters were typical for the time of this study is further supported when fathers' occupations are broken down according to nationality and place of origin.[403] The distribution of French Canadian fathers among occupational categories, shown in Table 24, was indeed typical for that time period. In Table 25 it can be seen that the reported occupations are associated with the employment opportunities found in the four most common regions of origin. This is further confirmed by examining the occupations of French Canadian fathers in the same locations (see Table 26).

---

[403] The places of origin used in this analysis are those where the nuns were born. They were not necessarily the places where there fathers were born, but rather where they had settled in adult life.

TABLE 24

NUMBER AND PERCENTAGE OF FRENCH CANADIAN FATHERS IN EACH OCCUPATIONAL GROUP

Occupational group	n	%
Farming	78	54.17
Trade	39	27.08
Sales	16	11.11
Other	10	6.94
Profession	1	0.70
TOTAL	144	100.00

TABLE 25

NUMBER AND PERCENTAGE OF MEMBERS OF EACH OCCUPATIONAL GROUP FOR ALBERTA, QUEBEC, SASKATCHEWAN AND THE USA

Group	Alberta n (%)	Quebec n (%)	Saskatchewan n (%)	USA n (%)
Farming	13 (68.42)	47 (52.81)	10 (76.92)	
Trade	3 (15.79)	23 (25.84)		12 (63.2)
Sales	3 (15.79)	10 (11.24)	2 (15.38)	2 (10.5)
Other		8 (8.99)	1 (7.70)	2 (10.5)
Profession		1 (1.12)		3 (15.8)
TOTAL	19 (100.00)	89 (100.00)	13 (100.00)	19 (100.0)

TABLE 26

NUMBER AND PERCENTAGE OF FRENCH CANADIAN FATHERS IN EACH OCCUPATIONAL GROUP FOR ALBERTA, QUEBEC, SASKATCHEWAN AND THE USA

Group	Alberta n (%)	Quebec n (%)	Saskatchewan n (%)	USA n (%)
Farming	11 (68.7)	45 (51.7)	9 (90.0)	
Trade	2 (12.5)	23 (26.4)		10 (83.3)
Sales	3 (18.8)	10 (11.5)	1 (10.0)	
Other		8 (9.2)		2 (16.7)
Profession		1 (1.2)		
TOTAL	16 (100.0)	87 (100.0)	10 (100.0)	12 (100.0)

As expected, French Canadian fathers from Quebec were found in every occupational group. The large number of fathers from that province may explain the greater variety of reported occupations. Yet, to draw such conclusion would be too simplistic. It is known that the majority of the fathers from Alberta, Saskatchewan and the United States had emigrated from Quebec. The fact that they mainly became farmers in the Prairies and tradesmen in the United States corresponded to the type of employment readily available for French Canadian in these locations. Although not shown in Table 26, the occupational distribution of the ten French Canadian fathers who resided in Ontario and in Manitoba also fell within the norm. Nine were farmers and one was a tradesman. Thus geography was an important determinant of occupational distribution.

In examining the results of Tables 25 through 27, it can be seen that the three fathers from Alberta who were not French Canadian were members of two occupational groups. The original data revealed that the two Polish men were farmers and that the Italian father worked in a coal mine. Interestingly, these two occupations were the most common ones for immigrants of these two nationalities.[404] Similarly, the only Metis men from this study came from Saskatchewan and was a clerk for the Hudson Bay Company.

TABLE 27

NUMBER AND PERCENTAGE OF FATHERS OF OTHER NATIONALITIES THEN FRENCH CANADIAN IN EACH OCCUPATIONAL GROUP

Group	AM	EN	GE	IR	IT	ME	PO	Total	%
Farming		2	1	1			2	6	33.3
Trade			1	1	1			3	16.7
Sales				2		1		3	16.7
Other		2						2	11.1
Profession	2		2					4	22.2
TOTAL								18	100.0

Abbreviations used: American (AM), English (EN), German (GE), Italian (IT), Irish (IR), Metis (ME), and Polish (PO).

Comparing the results presented in Tables 24 and 27, it is strikingly apparent that the fathers whose nationality was other than French Canadian were more evenly distributed across occupational groups than were French Canadian fathers. While 54.1% of the French Canadian fathers were farmers, only 33.3% of the other fathers lived from that occupation. The greatest difference was found in the professional category. Less than one percent of the French Canadian fathers were professionals while 22.2% of the fathers of other nationalities fell into the professional category. Again, this situation may be related to opportunities, since three of these men were from the United States, one was from Switzerland and one from Quebec. The small number of French Canadian fathers in the professional group may also be linked to the fact that, in general, French

---

[404] Howard Palmer, "Patterns of immigration and ethnic settlement in Alberta: 1880-1920", in ***Peoples of Alberta Portraits of Cultural Diversity***, ed. Howard Palmer and Tamara Palmer, (Saskatoon: Western Producer Prairie Books, 1985), 22 & 25.

Canadian nuns rarely came from families headed by a professional person. This issue is further discussed later in the chapter.

Family size

It is common practice to associate family size with father's occupation. In this study, it was possible to determine the number of children born in 176 families. The average number of children by family was 9.43, the standard deviation being 3.42, the mode thirteen, and the range two (3 families) to sixteen children (5 families). Forty-two percent of the nuns were from families of more than ten children, and 85.8% of the nuns had more then five siblings. The results presented in Tables 28 and 29 provide information about the range of number of children per family and about the mean number of children per family. Descriptive data presented in Table 28 show that families of 16 children were all French Canadian and had lived either in Quebec or in the United States. In four families the father was a farmer and in one a tradesman. Most families with 11 to 15 children lived in Quebec, on a farm and were of French Canadian nationality. In general the most typical families had 6 to 10 children; these families comprised 43.75% of the population.

Finally, the only subgroup which did not have families where the number of children was between two and five was the "Saskatchewan subgroup". That the majority of the French Canadian, Quebec and rural families were large was expected. However, the fact that three out of the four families headed by a professional had between 6 and 15 children was much more surprising, since even at that time professionals tended to have smaller families. To some degree these results seem to suggest that the number of children in families headed by farmers fell within the expected norms for that group in society, while families headed by professionals did not. A possible explanation for the phenomenon may be found in the fact that in Canada members of religious orders usually came from large families. Since large families were rare among professionals, it is thus not surprising that a small number of sisters had a father whose occupation fell within that work category. Conversely, it is logical that the small number of sisters whose fathers were professionals came from fairly large families. Seen from that standpoint, it thus appears logical that the mean number of children by subgroups (see Table 29) did not vary significantly (t-test failed to reveal statistically significant differences). Thus, it may be concluded that these families were rather homogenous in terms of number of children and that for this variable the minorities of the sample (e.g. sisters whose father was a professional, and sisters of other nationality than French Canadians) were similar to the majority.

TABLE 28

NUMBER OF FAMILIES BY RANGE OF NUMBER OF CHILDREN

Subgroup	n 2-5	n 6-10	n 11-15	n 16	TOTAL
FC	19	69	65	5	158
Not FC	6	8	4	0	18
Quebec	11	40	51	4	106
Alberta	5	9	4	0	18
Saskatchewan	0	9	4	0	13
United States	6	10	3	1	20
Farmers	7	31	41	2	81
Professionals	1	1	2	0	4
Not farmers or professionals	12	37	19	1	69
All families	25	77	69	5	176

Abbreviation used: French Canadian (FC). It is important to explain that the subgroups used in this Table are not mutually exclusive. Because of this, the results of the subgroup "all families" are not the sum of the results of all other subgroups. In other words families were counted only once to obtain the totals comprised in the "all families" subgroup.

TABLE 29

SUMMARY OF FAMILY STATISTICS

Subgroup	n	mean	s	mode	l	h
FC	158	9.7	3.4	13(21)	2(3)	16(5)
Not FC	18	7.3	3.3	7(4)	3(2)	15(1)
Quebec	106	10.3	3.3	13(20)	2(2)	16(4)
Alberta	18	7.4	2.9	8(3)	2(1)	12(2)
Saskatchewan	13	9.5	2.5	8(5)	7(2)	15(1)
United States	20	7.9	3.4	5(4)	3(1)	16(1)
Farmers	81	10.3	3.2	13(14)	3(1)	16(2)
Professionals	4	8.3	3.2	11(2)	5(1)	11(2)
Not farmers or professionals	69	8.6	3.1	5(9)	3(2)	16(1)
All families	176	9.4	3.4	13(22)	2(3)	16(5)

Abbreviations used: number of families (n), lowest number of children (l), highest number of children (h). The numbers in parenthesis represent the number of families and the given means represent the average number of children.

Relatives in religious life

It was found that at least 127 sisters in this study had relatives who had also chosen religious life. In total, these 127 nuns had 361 relatives who were either nuns, priests or brothers. Eighty-four or 23.27% of these relatives were Grey Nuns. Relatives were classified as siblings or non-siblings. The non-sibling category included aunts, uncles, cousins and nieces and nephews. The number and type of relatives who were Grey Nuns were determined. Fifty-seven nuns had siblings who had selected religious life, 25 had relatives others than siblings who were Grey Nuns and 45 had relatives in neither of the first two categories. Of the 57 nuns who had siblings in religious life, 32 had siblings who were Grey Nuns. Eight of those who had Grey Nun siblings also had additional brothers or sisters who were members of religious orders or secular priests. Twenty-three of the 32 nuns had one sister who was a Grey Nun, eight had two sisters belonging to the same order, and one even had three. There were 6 pairs of nuns who were siblings and who had both worked at the EGH. One of these pairs had a third sister who also belonged to the order. In total, the 32 nuns in this subset came from 26 families in which 64 daughters were Grey Nuns. Twenty four of these families were French Canadian (60 daughters) and two were Irish (4 daughters).

The results of the complete analysis of the 57 nuns who had siblings in religious life are presented in Table 30. These nuns had 77 female siblings and 25 male siblings who had chosen religious life. Including the 57 subjects of this study and their siblings, and counting every individual only once, a total number of 147 individuals was found. It is noteworthy that 122 (83%) individuals were women and that only 25 (17%) were men. The number of children per family who chose religious life ranged between two and eight. These siblings were distributed across 51 families. Forty-six families were French Canadian, three were Irish and two were German, while ninety-seven siblings were French Canadian, three were Irish and two were German.

TABLE 30

THE GREY NUNS AND THEIR SIBLINGS IN RELIGIOUS LIFE

Subjects n	Number of siblings	Female siblings total n	Male siblings total n
32	1	24	8
16	2	27	5
5	3	7	8
2	5	10	
1	6	3	3
1	7	6	1
57		77	25

Eighty-one nuns of this study had at least 259 non-sibling relatives who were in religious life.[405] Eleven nuns had both siblings and other relatives in religious orders. The results presented in Table 31 show that 157 of the non-sibling relatives were women. There were 52 Grey Nuns among them who comprised 32.12% of the female relatives. These Grey nuns were related to 28 subjects of this study. The number of male relatives was again lower; however the difference between male and female was smaller than in the sibling category. Nevertheless, the larger proportion of women should be expected since by nature of their service a large workforce was required in female religious orders. Only nine of these non-sibling relatives were not French Canadian; these included three who were German, two who were Italian, two who were Metis, one who was American, and one who was Polish. The 150 French Canadian relatives comprised more than 95% of these non-siblings.

TABLE 31

RELATIVES OTHER THAN SIBLINGS IN RELIGIOUS LIFE

Male relatives		Female relatives	
Uncles:	8	Aunts:	32
Cousins:	30	Cousins:	59
Nephews:	4	Nieces:	8
Not specified:	60	Not specified:	58
Total:	102	Total:	157

In summary, 60.77% (127) of the nuns of this study had some relatives in religious life. Two hundred and twenty-four or 64.82% of these relatives were women and 127 or 35.18% were men. The 27 nuns in this study who were not French Canadian had 14 relatives in religious life. In contrast, the 181 French Canadian nuns had 347 relatives who belonged to orders or were secular priests.[406] It is readily apparent that the French Canadian nuns had significantly more relatives in religious life than the nuns of other nationalities. In this study, the proportion of French Canadian nuns was 87.02%; their relatives who had chosen religious life comprised 96.12% of the total number of relatives. Nuns from other nationalities formed 12.98% of the population while their relatives comprised only 3.8% of the total number of individuals in this category. It is significant that more than half of the nuns had relatives in religious life and that so many of these were Grey Nuns. According to D'Allaire it has been demonstrated that the role modelling by members of religious orders often influenced younger relatives to follow in their footsteps.[407]

---

[405] In some cases the exact number of relatives was not specified.

[406] Based on 208 subjects because the nationality of one sister was not identified.

Having considered the family origins of the subjects of this study, it is of interest to examine if the results presented thus far correspond to those of other studies. The question of whether or not the origins of the EGH nuns were comparable to those of the average woman entering religious orders in Canada during the same period of time is of interest. In 1965, Lessard and Montminy published a census of Roman Catholic nuns of Canada.[408] The average age of the subjects of their study was 47.8 years in 1965.[409] At that time only 126 nuns of this sample were alive and their average age was 58.1 years. Thus, the sisters in this study were born significantly earlier then those in the Lessard and Montminy study. Yet it is strikingly apparent that, in general, the sisters of both samples came from similar backgrounds. Lessard and Montminy found that 82% of the sisters in their sample were from families of five children and over, and that 38% were from families of ten children and over.[410] These results are very comparable to those of this study. Approximately 85% of the subjects were from families of more than six children and 42% were from families of more than ten children. Similarly they found

---

[407] Micheline D'Allaire, ***Vingt ans de crise chez les religieuses du Québec, 1960-1980***, (Quebec: Editions Bergeron, 1983), 512.

[408] Marc Lessard and Jean-Paul Montminy, "The census of religious sisters of Canada", ***Donum Dei II***, (Ottawa: A publication of the Canadian Religious Conference, 1966): 273-401.

[409] Ibid., 315.

[410] Ibid., 334.

45.8% of their subjects came from families of 5 to 9 children, while in this study, 43.8% of the nuns came from families of 6 to 10 children.[411] In explaining their finding that nuns came from large families, Lessard and Montminy proposed that large families might have offered the best conditions for the development of religious vocation. Here, psycho-social factors may have been important. The spirit of self sacrifice was probably well developed in these families, and daughters who selected religious life may have been a source of prestige and pride for the families. They also proposed that recruitment efforts of religious orders may have been more directed at this type of family.[412] According to D'Allaire, material security may have been an additional reason to seek religious life.[413] These factors may also have been important ones for the subjects in the present study.

Lessard and Montminy also examined the occupations of the fathers of their subjects. Although significantly fewer of the sisters in their sample were from farm families (37.1% versus 51.9%), they nevertheless formed the most important group in both studies.[414] Lessard and Montminy found that 2.9% of the fathers were professionals as compared to 3.1% in this study. They reported that 35.8% of the fathers were tradesmen, while 25.9% was found in this study. The remaining fathers of the subjects of their sample constituted 24.2% of the population and 19.1% in this study.[415] Much of the variation between the results of the two studies may be related to differences in the classification of occupations. However, the difference are fairly small, and it is suggested that the fathers of both studies were distributed in relatively similar fashion among occupational groups. Lessard and Montminy did not provide a classification of places of origins. However, they reported that 64% of the nuns came from Quebec. This figure is again comparable to the figure in this project of 57.89%.[416] Lessard and Montminy and D'allaire also estimated that most sisters came from families of modest means.[417]

---

[411] Ibid.

[412] Ibid., 337.

[413] D'Allaire, ***Vingt ans de crise***, 57.

[414] Lessard and Montminy, "The census", 339. Statistical adjustments were made to facilitate comparison. Their reported percentages included missing cases while such cases are not included in this study. Since they reported the number of subjects for whom data was missing it was possible to established new percentages. Once adjusted the percentage of farmers was raised from 35.5 to 37.1. Similar adjustments were made for all other occupations.

[415] Ibid.

For all variables which could be compared there were many similarities between the results of this study and the findings of Lessard and Montminy. It is suggested as a result of this comparison that the background of the nuns in this study fell within the norm and that the majority of the sisters would have been typical women of the time among those joining religious orders in Canada between the late 1800's and the 1960's. Further analysis on additional variables adds additional weight this hypothesis.

Joining the Order

The purpose of this section is to shed light on some of the reasons why the sisters in this study decided to join a religious order. The range of ages at which the nuns became novices is examined as well as the span of time between novitiate and perpetual vows. As previously revealed, social and economic factors may have been among the factors which influenced young women to become nuns. Professional aspirations may also have played an important role. This would have been particularly the case in Quebec, where until the 1960's it was almost impossible for a lay women to attain higher levels of education. These reasons do not necessarily preclude the importance of religious faith which, must have been at least a primary factor. For the most part, the records consulted in this study did not reveal why the nuns in this study decided to join a religious order, and more specifically why the Grey Nuns. However, in a few cases reasons were explicitly stated, while in some others they were implicitly alluded to.

---

[416] Ibid.

[417] Ibid.; D'Allaire, *Vingt ans de crise*, 53.

It was found that two subjects were nurses prior to becoming Grey Nuns. Being in a work environment where nuns were numerous might have provided positive encouragement to join the order. The same forces might have been at play with one subject who had worked at a Grey Nuns' hospital prior to taking the veil. The records of one sister revealed that she had been a novice in the *Congrégation Notre-Dame* before joining the Grey Nuns. Since she became a nurse, it is possible that she left the *Congrégation* because of a professional choice.[418] Incidently, it was written in the file of one subject that: "Because she did not want to become a teacher, the Grey Nuns had seemed a logical choice."[419] This statement does not explicitly reveal that she wanted to become a nurse, but this may have been true since she became one. It was stated in the file of one subject that as a child she had visited the Motherhouse and had been "very impressed". Similarly, for another subject it was written that: "a visit paid to one of her aunts who was a Grey Nun pushed her to consider the same order." The few statements found in the original data suggest that professional reasons were a factor in the decision of these women as well as the influence exerted by relatives who were Grey Nuns.

It is of interest to examine the age at which the subjects went to the convent. Entry to novitiate and date of perpetual vows were available for 188 subjects.[420] The results presented in Table 32 through 34 provide information about actual and mean age at entry, duration of the novitiate and variations in it by decades of entry. The sisters who worked at the EGH became novices between the years of 1860 (1 case) and 1958 (1 case). Results presented in Table 17 show that age at entry ranged from 16 (4 cases) to 45 (1 case). Average age at entry for the entire sample was 21.1 years. The results also show that the mean age at entry did not change significantly from decade to decade. If the first and last decades are excluded the mean age ranged from 20.2 to 21.6.

---

[418] The Congrégation Notre-Dame is predominantly a teaching order.

[419] Free translation of written statement.

[420] Before the novice stage a recruit was a postulant. The *postulat* usually lasted only a few months. Therefore using the age at the beginning of the novitiate as age of entry is fairly accurate.

TABLE 32

MEAN AGE AT ENTRANCE TO NOVITIATE BY DECADE OF ENTRY

Decade	n	mean	range	mode (n)
1860-1869	1	18	---	---
1870-1879	6	20.3	17-26	17 (3)
1880-1889	5	20.2	17-24	---
1890-1899	23	21.6	16-31	22 (5)
1900-1909	24	21.5	16-42	21 (5)
1910-1919	33	20.9	17-37	18 (6)
1920-1929	35	21.4	16-27	20 (9)
1930-1939	38	20.3	17-26	19,20 (9)
1940-1949	17	21.5	17-29	21 (4)
1950-1959	6	25.3	18-45	---
	188	21.1	16-45	20 (30)

The results presented in Tables 33 and 34 show that there was a much greater variation in the duration of the novitiate. The 180 sisters for whom data was available took between two and nine years before making perpetual vows. A little more than half or 91 sisters (50.6%) took between two and five years. The remaining 89 subjects (49.3%) were novices for a period of six to nine years. In both Tables it can be clearly seen that the number of years taken to complete the novitiate period increased significantly over time. It is also remarkable that the greater the number of sisters per decade, the larger the variation in the number of years of novitiate (see Table 33). The question thus arises: what are the factors which may explain that age at entry to convent showed little variation while the duration of the novitiate increased through time?

TABLE 33

NUMBER OF SUBJECTS BY NUMBER OF YEARS OF NOVITIATE BY DECADE

Decade	2	3	4	5	6	7	8	9
1860-69	1							
1870-79	1	5						
1880-89	2	2						
1890-99	14	6				1	1	
1900-09	11	4			2	5	2	
1910-19	2	3	2	5	12	3	4	
1920-29	3	1	2	12	13			1
1930-39		1	1	10	21	3	1	
1940-49				3	3	4	7	
1950-59					2	1	2	1
	34	22	5	30	53	17	17	2

A number of possible explanations may be suggested to explain the stability of the age at entry. Results presented in later pages show that most of the nuns who became nurses or technicians studied in schools operated by the Grey Nuns' Order. Most of them began their professional education soon after becoming a novice; thus they would have started to study around the age of 20. Since, in society in general, the age at which women entered nursing or technical program remained fairly stable throughout the period of time being studied it seems logical that the situation would have been similar for Grey Nuns. The age of entry to convent also coincided with the time at which women began to take decisions which would affect their adult life. It is apparent that as the age at marriage increased in society, the age at which perpetual vows were taken also increased. Thus, in both cases, as the years went by, young women waited longer before taking lifetime decisions. As in society, variations existed and it is reasonable to suggest that these were linked to personal factors. Maturity and certainty about these important decisions may have been important ones. This hypothesis was reinforced by the fact that the average number of years before perpetual vows were taken was not correlated to the age at which the sisters became novices.

TABLE 34

MEAN NUMBER OF YEARS OF NOVITIATE BY DECADE OF ENTRY

Decade	n of subjects	Mean
1860-69	1	2.0
1870-79	6	2.8
1880-89	4	2.5
1890-99	22	2.8
1900-09	24	4.1
1910-19	31	5.5
1920-29	32	5.1
1930-39	37	5.7
1940-49	17	6.9
1950-59	6	7.3
Total	180	5.0

The increased duration of the novitiate was also related to the rules of the order. For example, it was found that in the 1930's the minimum duration of the novitiate was extended to five years. At that time, perpetual vows could not be taken until a subject had reached civil majority (21 years). Those who took longer than the prescribed minimum number of years were simply given the chance to reflect for a longer period of time. Maturity and readiness were thus considered to be important factors.[421]

---

[421] The results presented here are based on personal communication with Sr Fernande Champagne, SGM, Archivist for the Province of Alberta of the Grey Nuns of Montreal.

Education of the sisters

The purpose of this section is to examine the education received by the sisters prior to entering the order and prior to acquiring technical or professional education. The number of years of elementary and/or "secondary"[422] education was available for 84 nuns. The results presented in Table 35 show the average number of years of education by decade of birth. Even if the number of subjects was relatively small, results indicated that in general the level of education increased with time. The number of years of education of these 84 sisters varied between 4 (1 case) and 13 (1 case) years, with a mean of 9.5. Eight subjects (9.5%) had between four and six years of education, 32 (38.1%) had between seven and nine years and 44 (52.4%) had between ten and thirteen years. Thus, more than half of these subjects had at least ten years of education.

TABLE 35

NUMBER OF YEARS OF EDUCATION BY DECADE OF BIRTH

decade	n	mean
1860-1869	2	9.5
1870-1879	5	8.6
1880-1889	6	7.2
1890-1899	14	8.4
1900-1909	18	9.8
1910-1919	25	9.8
1920-1929	8	10.7
1930-1939	6	11.2

Based on the classification by occupation of the EGH nuns, it was possible to compare the number of years of schooling by category of employment.[423] The results presented in Table 36 represent the average number of years of education by occupational category, and by decade. Because of the larger number of missing cases, generalizations to the entire population cannot be made. However, it is apparent that the mean number of years of schooling for the sisters who were labourers was consistently lower than that of the nuns in other occupations. The average number of years of education these subjects attained was almost three years lower than the average for the total group. The mean number of years of education of the sacristans also fell under that mean, but the difference was much smaller. The sisters who had nursing, office or technical responsibilities were more educated than the other nuns.

---

[422] Secondary education is used because there is no equivalent in the English language. The secondary years of education include grade seven to twelve.

[423] This classification is discussed at length in another section of this chapter.

TABLE 36

AVERAGE NUMBER OF YEARS OF EDUCATION BY OCCUPATION
AND BY DECADE OF BIRTH

Decade	N	L	O	T	A	S
1860-69	7.0 (1)					
1870-79	10.0 (3)	6.5 (2)				
1880-89	8.0 (2)	6.8 (4)				
1890-99	7.0 (7)	5.0 (1)	10.7 (3)	12.0 (1)	10.0 (2)	
1900-09	10.0 (11)	7.5 (2)	10.0 (3)	12.0 (1)	10.0 (1)	
1910-19	11.4 (9)	7.4 (7)	10.3 (6)	12.0 (1)		8.5 (2)
1920-29	11.7 (3)		12.0 (1)	12.0 (1)	9.5 (2)	8.0 (1)
1930-39	12.0 (2)		11.0 (2)	9.0 (1)		
Total	9.8 (38)	6.8 (16)	10.5 (15)	11.4 (5)	9.8 (5)	8.3 (3)

Abbreviations used: Nurse (N), Labourer (L), Office work (O), Technician (T), Nursing Aide (A), Sacristan (S). The number in parenthesis represents the number of subjects.

Sixty-five percent (41) of the subjects of the four most educated occupational groups had ten years or more of education. The raw data also showed that 22 of these subjects had less then ten years of education. Eighteen of these were in the nursing field, three did office work and one was a technician. That the majority of them were found in the nursing field was somewhat surprising. This may have occurred for several reasons. Thirteen of these nurses were born prior to 1900, a time at which the academic requirements for admission to nursing were much lower than in later years. The older sisters in this group began practising as nurses even before nursing schools were established. Considering this, and that the education of women was not a priority at that time, it is hardly surprising that these subjects would have been less educated than their successors. Notably the only three office workers who had less than ten years of education were born prior to 1890. Taking into account the decades of birth of the subjects included in this analysis, it appears that these nuns were fairly well educated. It is suspected that they were at least as well educated than most of their contemporaries.

Education of nurses

Records of the sisters revealed that 117 subjects, or 55.9% of the total population were nurses. The purpose in this section is to examine the available data about the basic nursing education of these nurses. It is known that 85 of these sisters had formal education in nursing since their records revealed the name of their *Alma Mater*. It was impossible to determine if the remaining 32 nurses had had formal nursing education. However, considering that the first two nurses for whom a school of nursing could be identified were born in 1869, it is very likely that the ten subjects born prior to that time did not have the opportunity to go to a nursing school, especially since eight were French Canadian (6 from Quebec and 2 from the United States) and two were Irish women from Quebec. Support for this hypothesis is based on deductions made by considering the dates on which the first schools of nursing of Quebec were established. The first two schools of nursing of Quebec opened their doors in 1890 (Montreal General Hospital School of Nursing) and in 1898 (Ecole d'infirmières de l'Hôpital Notre-Dame).[424] The two sisters who were born in 1869 and who held a nursing diploma were graduates of the Notre-Dame school of nursing. Since the school opened in 1898, they could not have began their formal nursing education until at least the age of 29. In 1898, the 10 subjects born prior to 1869 were between the ages of 31 and 51 ($\bar{x}$: 39.5). Considering their ages it is unlikely that they would have enrolled in a formal program of nursing education. It is also unlikely that the two Irish subjects would have been sent by their parents or the Order to study at the Montreal General Hospital school of nursing since it was not a Catholic institution.

---

[424] André Petitat, ***Les infirmières de la vocation à la profession***, (Montreal: Boréal, 1989), 187. The school of nursing at Notre-Dame was the first school at which nursing instruction was offered in the French language in Canada.

It is more difficult to suggest hypotheses to explain the development of nursing expertise in the remaining 20 subjects for whom school of nursing information is lacking. These sisters were born between 1869 and 1901. However, because of their dates of birth and the years during which they were employed in nursing, many of them must have graduated from recognized programs of nursing education. Information was also missing for two subjects born in 1907 and 1921. Since legislation to establish nursing registration was in place by the time of their adulthood, it is almost certain that they would have graduated from a nursing school.[425]

The results presented in Table 37 demonstrate that the 85 nurses for whom a school of nursing is known graduated from fourteen institutions. As expected, most subjects went to schools of nursing operated by the Grey Nuns. Only two subjects did not and both were already nurses when they took the veil. They graduated from the Quo Vadis school of nursing and from the New Hampshire State Hospital School of Nursing. Thirty-six subjects graduated from Notre-Dame. This is not surprising since Notre-Dame was in the same city as the Motherhouse, was the oldest school of nursing operated by the order, and was one of the largest of Canada. It would also appear logical that 25 nuns (29.4%) studied in Alberta and that 12 (14.1%) graduated from other schools located in the Prairie Provinces. Study in the West would have assisted these nuns to adapt to the part of the country which was a strange land for many of them.

---

[425] Between 1910 and 1922 all Canadian provinces adopted legislations regulating nursing practice. Janet Ross Kerr, "Professionalization in Canadian nursing," in ***Canadian nursing issues and perspectives***, 2d ed., ed. Janet Ross Kerr and Jannetta MacPhail (Toronto: Mosby Year Book, 1992), 29.

TABLE 37

NUMBER AND PERCENTAGE OF SUBJECTS BY SCHOOLS OF NURSING

School of nursing	Location	n	%
Notre-Dame	Montreal QU	31	36.5
Edmonton General	Edmonton AB	12	14.1
Holy Cross	Calgary AB	12	14.1
St. Vincent	Toledo OH	7	8.2
St. Boniface	St. Boniface MA	5	5.9
St. Paul	Saskatoon SA	5	5.9
St. Jean	St. Jean QU	4	4.7
La Tuque	La Tuque QU	2	2.3
Regina (Grey Nun)	Regina SA	2	2.3
Holy Ghost	Cambridge MA	1	1.2
NH State	? NH	1	1,2
Quo Vadis	Toronto ON	1	1.2
St. Paul	St. Paul AB	1	1.2
St. Peter	New-Brunswick NJ	1	1.2

The results presented in Table 38 show that the 85 sisters were born between 1869 (2 cases) and 1936 (1 case). Of these, fifty-eight subjects (68.2%) were born between 1890 and 1919. The number of subjects per decade of birth by school of nursing was examined. No patterns could be established except that at least one subject per decade studied at Notre-Dame and that all subjects who studied in Toledo were born between 1870 and 1909. As more schools of nursing developed in Canada, it may have been less necessary to send sisters to study in the United States.

The place of origin of all nurses is closely examined in later pages. However, it is relevant at this point to discuss the relationship between place of origin and school of nursing. The results presented in Table 39 show the number of subjects by place of origin and by school location. It is important to note that a school of nursing could be identified for all subjects from Alberta, Manitoba, Ontario and Saskatchewan (this was not the case for sisters of other places of origin). A total of nineteen subjects came from these provinces and only seven studied in the province were they were born. Some of the families of the other twelve subjects may have migrated within these provinces. However, this is not known and it can only be suggested that the majority of the nurses from these four locations studied in other provinces than their own. Mobility was certainly present for the United States' nurses of this sample of whom only three (27.2%) studied in their country of birth. It is also significant that nineteen subjects from Quebec, who comprised 36.5% of that group, studied abroad.

On the whole these results reflect the geographical mobility that was commonly seen in the Grey Nuns' Order. An ancient French Canadian proverb states: "Who takes husband takes country". Applied here, it could be transposed as "Who takes the veil takes country", country meaning any place where the Grey Nuns operated a school of nursing.

TABLE 38

NUMBER AND PERCENTAGE OF NURSE BORN PER DECADE

Decade	n	%
1860-1869	2	2.4
1870-1879	12	14.1
1880-1889	6	7.1
1890-1899	21	24.7
1900-1909	17	20.0
1910-1919	20	23.5
1920-1929	4	4.7
1930-1939	3	3.5
Total	85	100.0

TABLE 39

NUMBER OF NURSES BY PLACE OF ORIGIN AND SCHOOL LOCATION

	QU	USA	AB	SA	MA	ON	Total
QU	33	5	11	2	1		52
USA	2	3	5		1		11
AB			4	2		1	7
SA	1		2	1	1		5
MA				1	2		3
ON	1	1	2				4
Other		1	1	1			3
Total	37	10	25	7	5	1	

* Places of origin in "ordinate" and schools' locations in "axis".

A nursing diploma is not the end

One of the most interesting results of this study is that 25 of the 117 nuns who were nurses acquired university education.[426] These subjects comprised 21.4% of the nurses. Considering that in 1991, in Canada only one nurse in ten was educated at the baccalaureate level and that the proportion of nurses who have gone to graduate school remained under 2%, the percentage of the nursing sisters in this study who had some university education is remarkable.[427] Results in Table 40 show the number of sisters who had university education by decade of birth. In order to glean a better understanding of the magnitude of the increase in education over time, the percentage of nurses who had university education was calculated by periods of twenty years. It was found that the three nuns born between 1870 and 1889 represented 16.7% of all the nuns who were born in that decade and were nurses. The seven subjects born between 1890 and 1909 represented 18.4% of the subjects of their cohort, and the thirteen subjects born between 1910 and 1929 comprised 54.2% of the nursing sisters of that decade. Finally, the two nuns born after 1930 accounted for 66.6% of the subjects born after that date. Even if in that last decade there were only three nurses the fact remains that the majority had gone to university.

---

[426] At least two nurses had graduated from the University of Montreal Normal School. As this type of education was not directly related to nursing, these subjects were not included in this analysis.

[427] Janet Ross Kerr, "Educating nurses for the future", ***Canadian nursing issues***, 260.

The university education of these 25 subjects ranged from the certificate to the master's level. Three sisters held certificates in hospital administration from the Institut Marguerite d'Youville.[428] One of them later obtained a Bachelor of Science in nursing. Twenty-two subjects had a baccalaureate degree. Twenty-one obtained either a Bachelor of Science in Nursing, a Bachelor of Hospital Administration or a Bachelor of Public Hygiene degree.[429] The remaining subject obtained a Bachelor of Science of Pharmacy from Columbus University. Excluding this last subject, the sisters had studied at five institutions. The majority of them (17 or 80.9%) had received their education at the Institut Marguerite d'Youville. The remaining four sisters had studied at Boston College, St. Louis University, The Catholic University of Washington and the University of Toledo. Four sisters obtained masters' degrees. They all studied in different fields: Master of Hospital Sciences from the Catholic University of America in Washington; Master of Religious Studies, Master of Social and Political Science, and Master of Social Services from the University of Montreal.

---

[428] Although the *Institut* was officially created in 1934, the Grey Nuns, who operated the school, began to offer summer sessions in 1923. Between 1924 and 1934, four certificates were offered: school of nursing management, hospital management, hospital hygiene and social service. A bachelor of science could be obtained by accumulating three certificates. The *Institut* became the *Faculté des Sciences Infirmières* of the University of Montreal in 1962. Petitat, ***Les infirmières***, 189-190.

[429] It was not always possible to determine the specific degree obtained by the graduates from the *Institut Marguerite d'Youville*. However, these three fields of study were found in some sisters' files and they corresponded to the available fields of specialization of the time.

TABLE 40

NUMBER OF SISTERS WITH UNIVERSITY EDUCATION
BY DECADE OF BIRTH

Decade	n	%
1870-1879	3	12.0
1880-1889	-	---
1890-1899	5	20.0
1900-1909	2	8.0
1910-1919	11	44.0
1920-1929	2	8.0
1930-1939	2	8.0
Total	25	100.0

Years of graduation were available for ten subjects. Seven had received their education prior to their appointment at the EGH and three had returned to this hospital after their education was completed. These sisters graduated between 1925 and 1967. The subject who held a Masters of Hospital Science was among them. She became the director of the School of Nursing of the EGH in 1965.

Twenty-three of the sisters were French Canadian and two were of German descent. Fourteen came from Quebec, three from Saskatchewan, three from the United States, two from Alberta, one from Manitoba, one from Ontario and one from Prince Edward Island. Their fathers were distributed among every occupational group. Ten were farmers, five were tradesmen and one father was found in each of the other possible occupational groups.[430]

The study of Lessard and Montminy revealed that in 1965, 481 nuns who were nurses held a Bachelor of Science degree, and that 80 had masters level education.[431]

---

[430] Father occupation was found for seven subjects.

[431] Lessard and Montminy, "The census", 340-341.

These figures further confirm that nurses who belonged to a sisterhood were more educated than lay nurses. In general, Canadian religious orders encouraged their members to acquire further knowledge. Nuns were also advantaged as compared to lay women because the cost of their education was covered by their order. In many cases, going back to school was fraught with financial difficulty for lay nurses. It must also be understood that during the years under investigation, for the majority of lay women, nursing was an interlude before marriage. In addition, since most hospitals had regulations prohibiting the employment of married nurses, further education was rarely envisaged by those who chose matrimonial life. However, it seems evident that there were few social forces that pressured religious orders to send their members to university. Since they could have chosen not to do so, those in the order must have valued the education provided at the university level.

Among the French Canadian nursing orders, the Grey Nuns attained a central place and considerable recognition in the field of advanced education for nurses. The creation of their own *Institut* contributed to their position by providing an accessible means of satisfying the educational needs of the members of the Order. The nursing nuns of the EGH were among the numerous Grey Nuns who directly benefited from the *Institut*. Indeed, more than one third of the women who graduated from the Institut Marguerite d'Youville between 1935 and 1960 were Grey Nuns.[432] These figures show that the Grey Nuns probably believed that nursing care and hospital management could be improved by the acquisition of advanced knowledge. That the Grey Nuns created the first Canadian university program of nursing where the language of instruction was French is the best evidence of their regard for advanced preparation in nursing.

---

[432] Soeurs Grises de Montreal, ***Institut Marguerite d'Youville, Publication du 25e anniversaire***, (Montreal: Séguin et Associés, 1960). Eighty-five of the 223 graduates were Grey Nuns, 70 belonged to other religious orders and 68 were lay nurses. Considering the number of religious orders which existed in Quebec, a very small proportion of the nurses in these orders would have been comprised of these graduates. Although other orders might have sent their nurses to other universities, it is proposed that considering that a limited number of sisters would have been able to study in the English language, the number could not have been considerable.

Evidence suggests that the Grey Nuns involvement in health care beyond the borders of the province of Quebec may in large part explain why they were the founders of that first program. Their involvement in other provinces would have made them more aware of the innovations in nursing education that were taking place across the country. In 1921, Mother Allaire, then the vice-president of the Saskatchewan Nurses Association, organized the first summer course for directors of nursing schools and hospital administrators in Western Canada. Ethel Johns, the first director of the University of British Columbia School of Nursing, the oldest university school of Canada, was among the professors.[433] Meeting Ethel Johns must have been inspiring for Mother Allaire. A few years later she founded the *Institut* and it may have been during this summer course, in Saskatchewan, that her plans for Montreal started to take shape.

Sisters occupations

One of the characteristics of the hospitals operated by sisterhoods was that nuns were found in almost every sphere of activities. In this regard the EGH was no exception. The purpose in this section is to examine the number of nuns by occupation and to establish wether or not these occupations were related to other variables such as nationality and father's occupation. The sisters were grouped into seven occupational categories. These categories were: labourer, nurse, nursing aide, office worker, sacristan, superior and technician.[434] Three of these groups contained more than one occupation. The technician category included: laboratory technician, X-Ray technician and medical records archivist. The office workers comprised: accountant, *econome*, and other office workers for whom the precise occupation was not available.[435] The labourers included cooks, laundry worker, seamstress, and some sisters whose employment varied within these fields.

---

[433] Edouard Desjardins, Suzanne Giroux, and Eileen Flanagan, ***Histoire de la profession infirmière au Québec***, (Montreal: Association des Infirmières et Infirmiers de la Province de Quebec, 1970), 127; Ethel Johns was a remarkable nurse and leader. Her biography written by Street is highly recommended for further information: Margaret Street, ***Watch-fires on the mountains: the life and writings of Ethel Johns***, (Toronto: University of Toronto Press, 1973.)

[434] The function of "superior" was classified as an occupational group because it was the only recorded function in the files of two subjects. A detailed analysis of all superiors is presented later.

It is very likely that some of the kitchen workers may had received some specialized education in food and nutrition. However, it was impossible to determine if such workers existed in this sample. It must also be understood that during the first years the hospital was in operation, nurses assumed all functions. For example, six of the early nurses were also classified as pharmacists. The meaning of the term "pharmacist" changed during the first part of the twentieth century. At the turn of that century, the word "pharmacist" had two meanings: a nurse in charge of what would be called today the hospital pharmacy and the nurse responsible for the distribution of medications on a nursing unit.[436] Similarly, labourers and sacristans often took on a number of functions within these occupations. To give the best possible picture of the EGH, the sisters were classified in the category corresponding to the position they occupied all the time or most of the time at this hospital. In total, 117 (58.2%) subjects were nurses, 33 (16.4%) were office workers, 28 (13.9%) were labourers, eight (4.0%) were technicians, seven (3.5%) were nursing aides, six (3.0%) were sacristans and two (1.00%) were superiors. Eight subjects (seven French Canadians and one of unknown origin) were not included in this distribution. There were three subjects for whom an occupation could not be identified and four who were retired nuns. However, these four nuns had some form of work while they were at the EGH. Two of them were retired nurses, one visited patients and one was listed as an "hostess" for visitors. The other two retired nuns had been teachers; one undertook "light tasks" in the laundry department, while the other assumed housemother functions at the school of nursing. It is interesting to note that three of these nuns spent their retired years in occupations where some of their professional skills could have been used.

---

[435] The *econome* was the equivalent of the minister of finance of a religious order.

[436] Diane Bélanger and Lucie Rozon, ***Les religieuses du Québec***, (Montreal: Librairie Expression, 1982), 227.

More advanced preparation was required for some of the sisters who were in three occupational categories. The education of nurses has already been discussed, but the preparation of accountants and technicians needs to be addressed. More than half of the office workers were classified as accountants (17 of them). It was found that at least four of these had formal education in the field. It was also noted that most of the others had at least ten years of education. It is very likely that a large proportion of the subjects from Quebec may have had done a "commercial course". This course, which could be completed by the end of grade ten, specifically focused on skills required for office work. Five of the six laboratory and X-Ray technicians had education in these fields.[437] All of them graduated from the EGH. Finally, one of the three medical records archivist had a diploma in the field which was obtained at the Grey Nuns' Hospital in Regina.

Occupational distributions according to nationality and place of origin are presented in Tables 41 and 42. French Canadian sisters were the only ones distributed among all occupational categories. This is far from surprising considering the size of this group. The results presented in Table 41 show the percentage of subjects represented by each occupational group by nationality. The fact that all nursing aides and superiors were French Canadian may explain why the percentage of sisters of other nationalities was greater than the percentage of French Canadians in the nursing occupational group. It is notable that all German, English and American subjects were found in the nursing and office work categories. However, as the number of subjects was small, it is difficult to determine if their was a direct link between their nationality and the work they did. Similarly, the only Metis sister and one of the Polish nuns were labourers. Again conclusions should not be drawn hastily since 14,6% of the French Canadians were also found in this category of employment. In summary, it is only safe to suggest that in this sample there was some homogeneity in occupational distribution among the subjects of other origin than French Canadian.

---

[437] Three of the subjects had education in both fields.

TABLE 41

NUMBER AND PERCENTAGE OF SISTERS BY NATIONALITY BY OCCUPATION

	N	O	L	T	A	S	SU	Total
FC	98(56.3)	29(16.7)	26(14.9)	6 (3.5)	7(4.0)	6 (3.5)	2(1.1)	174
IR	7(77.8)	1(11.1)		1(11.1)				9
GE	5(83.3)	1(16.7)						6
EN	4(80.0)	1(20.0)						5
AM	2(66.6)	1(33.3)						3
PO			1 (50.0)	1(50.0)				2
ME			1(100.0)					1
IT						1(100.0)		1
NFC	18(66.7)	4(14.8)	2 (7.4)			1 (3.7)		27

Abbreviations used: French Canadian (FC), Irish (IR), German (GE), English (EN), American (AM), Polish (PO), Italian (IT), Not French Canadian (NFC); Nurse (N), Office (O), Labourer (L), Technician (T), Nursing Aid (A), Sacristan (S), Superior (SU). The numbers in parentheses represent the percentages within that nationality.

The situation is different when one contrasts the sisters' occupations with places of origin (see Table 42). Subjects from the three most common places of origin were present in almost all categories. However, in examining percentages, it was readily apparent that the Saskatchewan and Alberta sisters were under represented in the nursing category, while they were over represented in the technician and labourer categories. It can also be seen that in general the nuns not born in Quebec were more numerous than the nuns of Quebec in every occupational group except nursing and superior. It is difficult to determine why these variations were found. That more than sixty percent of the labourers were from Alberta and Saskatchewan may be explained by the nature of this work. As the skills required here were less specialized, there may have been a small number of valid reasons to justify a posting very far away from the sisters' places of origin. It is known that nurses were regularly transferred when their expertise in a particular field was needed elsewhere. For example, one nun came to the EGH specifically because she had extensive knowledge of the treatment of patients affected by poliomyelitis. Another nurse came because of her experience in hospital planning and construction.[438] Unfortunately, this hypothesis could have been thoroughly explored only if data from other provinces had been available. Nevertheless, even if there were variations, it appeared that the place of origin did not automatically dictate the occupation of a sister.

TABLE 42

NUMBER AND PERCENTAGE OF SISTERS BY PLACE OF ORIGIN BY OCCUPATION

	N	O	L	T	A	S	SU	Total
QU	73(63.5)	15(31.1)	14(12.2)	2(1.7)	3(2.6)	6(5.2)	2(1.7)	115
US	15(62.5)	2(8.3)	5(20.8)	1(4.2)	1(4.2)			24
AB	7(36.8)	2(10.5)	6(31.6)	2(10.5)	1(5.3)	1(5.3)		19
SA	5(38.5)	2(15.4)	4(30.7)	2(15.4)				13
NB		3(50.0)	1(16.7)		2(33.3)			6
ON	4(66.7)		1(16.7)	1(16.7)				6
MA	3(60.0)	2(40.0)						5
O	6(60.0)	3(30.0)	1(10.0)					10
NQU	40(48.1)	14(16.9)	18(21,1)	6(7.2)	4(4.8)	1(1.2)		83

Abbreviations used: Quebec (QU), United States (US), Alberta (AB), Saskatchewan (SA), New-Brunswick (NB), Ontario (ON), Manitoba (MA), Other (O), Not Quebec (NQU); Nurse (N), Office (O), Labourer (L), Technician (T), Nursing Aide (A), Sacristan (S), Superior (SU). The numbers in parentheses represent the percentages within places of origin.

Of final interest in this analysis, the relationship between fathers' and daughters' occupations was examined. Results of this comparison are presented in Table 43. Nurses and office workers had fathers in every occupational category. The fathers of the two superiors were merchant (sales) and teacher (profession). There were subjects in all remaining occupations whose fathers were farmers or tradesmen. Some of the fathers of the nuns who were labourers, and the father of one nursing aide worked in sales related fields. It is apparent that the daughters of the professionals all worked in fields that could have been considered more prestigious. The siblings who worked at the EGH and for whom father's occupations were known all had fathers who were farmers. Two pairs of siblings were nurses, one pair included a nurse and a seamstress and in one set, one was a sacristan and one was a kitchen worker. In general, the results about the relationship between father and daughter occupation show that personal attributes and talents may have been more important than this component of family background in the attribution of work assignments. The results presented in the next section reinforce this hypothesis.

---

[438] Geographical mobility is further addressed in the chapter where the EGH workforce is discussed.

TABLE 43

SISTERS' OCCUPATIONS BY FATHERS' OCCUPATIONS

	Farm (%)	Trade (%)	Sales (%)	Other (%)	Profession (%)
N	41 (50.6)	17 (43.6)	10 (52.6)	8 (72.7)	3 (60.0)
O	8 (9.9)	7 (17.9)	4 (21.0)	3 (27.3)	1 (20.0)
L	20 (24.7)	9 (23.1)	3 (15.8)		
T	5 (6.2)	1 (2.6)			
A	3 (3.7)	2 (5.1)	1 (5.3)		
S	4 (4.9)	3 (7.7)			
SU			1 (5.3)		1 (20.0)
Total	81(100.0)	39(100.0)	19(100.0)	11(100.0)	5(100.0)

Abbreviations used: Nurse (N), Office (O), Labourer (L), Technician (T), Nursing Aide (A), Sacristan (S), Superior (SU). The number in parentheses represent percentages.

Superiors and directors

Nationality, place of origin, occupation and age at the beginning of mandate were examined for the superiors of the hospital and the directors of the school of nursing. Sixteen superiors and thirteen directors assumed the respective offices during the years under investigation.

One superior had filled a variety of positions including work of manual nature as a seamstress and in the laundry department. Two superiors had primarily been engaged in administrative positions (accounting and *economat*). Two others, referred to earlier, seemed to have been only superiors; one of these subjects later became the Superior Provincial for the province of Manitoba. Eleven of the sixteen superiors were nurses. Of these, two graduated from Notre-Dame, and one from each the Holy Cross Hospital of Calgary, and the Grey Nuns Hospitals of Regina, St. Boniface and St. Jean. It is noteworthy that one of these nurses had been superior at Notre-Dame immediately prior to her appointment at the EGH. Two of these nurses had been directors of schools of nursing (one at the EGH). Records for these sisters showed that two of them were educated at the baccalaureate level. However, it was not possible to determine if they held these qualifications during their tenure at the EGH. Eleven of the superiors were French Canadian, nine being from Quebec, one from Saskatchewan and one for whom the place of origin was not known. Three subjects were from the United States and were of American, German and Irish descent.[439] Therefore being French Canadian and from Quebec was the most common background for the individuals who were superiors.

Father's occupation could be traced for eight of the sixteen subjects. The results presented in Table 44 show that these superiors most commonly had fathers who were professionals. The father of the subject from Quebec was a politician (lieutenant governor), while those of the two sisters from the United States were a pharmacist and a teacher. These sisters also represented 60% of the total number of daughters of professionals. One wonders if their family background influenced their selection for positions in the order. It may have been that their upbringing gave them a better preparation for leadership positions. Nevertheless, 62.5% of the superiors for whom father's occupation was known came from modest backgrounds. Humble origins would not then have prohibited upward mobility.

---

[439] There were two superiors for whom places of origin and nationality were unknown. It is suggested by their surname that one was probably English (use in the broad sense) while the other was probably French Canadian.

TABLE 44

OCCUPATIONS OF THE FATHERS OF THE SUPERIORS BY PLACE OF ORIGIN

	QU	US	SA	Total (%)
Farming	1		1	2(25.0)
Trade	1			1(12.5)
Sales	1	1		2(25.0)
Profession	1	2		3(37.5)

Finally, the sixteen superiors began their terms at the EGH between the ages of 36 (two subjects) and 62 (one subject). Seven were in their fourth decade and seven in their 50's; average age at appointment was 48.4 years of age.

As expected, the thirteen directors of the school of nursing were all nurses. Three had graduated from Notre-Dame, two from the EGH, two from St. Vincent in Toledo, one from the Grey Nuns' Hospital in Regina, and one from St-Peter's in New Brunswick (New Jersey); seven of them had further education. The highest level of education attained by five of these sisters was a baccalaureate degree, while it was a master's degree for the other two subjects. While in office, six sisters were baccalaureate prepared and one was masters prepared. After 1937 all directors had at least a baccalaureate degree.[440]

The directors for whom places of origin and nationality are known were from four locations and three ethnic groups. Results presented in Table 45 show that more than half of these sisters came from Quebec. It is interesting to note that the two Irish sisters constituted the entire population of Irish nuns from Quebec. The United States was also well represented. The large proportion of sisters from these two locations may be related to the large representation of subjects from these locations in the population under investigation.

---

[440] Further analysis on this topic is presented in the chapter devoted to the school of nursing.

TABLE 45

NATIONALITY OF THE DIRECTORS
BY PLACE OF ORIGIN

	QU	US	AB	MA	Total (%)
FC	4	1	1	1	7 (63.6)
IR	2	1			3 (27.3)
GE		1			1 (9.1)
Total	6(54.5)	3(27.3)	1(9.1)	1(9.1)	11(100.0)

Unlike the superiors, none of the directors had fathers who were professionals. Four fathers were farmers, two were tradesmen, one worked in the sales sector and one occupied a position classified as "other" (registrar). In general, the directors were significantly younger than the superiors when they were assigned to this leadership position. The average age at the beginning of mandate was 41.3 years of age, the youngest being 31, while the oldest was 49. Five sisters were in their 30's and seven in their 40's.[441] The difference in age between the directors and the superiors was probably related to the level of responsibility associated with each position. Since the role of the superior was more complex, it seems reasonable that more experienced individuals would have been selected for this position.

One of the interesting results of this analysis was that it was found that subjects of nationalities other than French Canadian and sisters born in the United States were well represented in leadership positions. Combining the results obtained for both positions, it was found that eighteen were French Canadian and that seven were from other nationalities. Respectively, these subjects comprised 9.94% of the French

---

[441] One subject for whom the age at beginning of mandate could not be determined.

Canadian population and 25.9% of the population of other ethnicity. Similarly the fifteen directors/superiors who came from Quebec comprised only 12.4% of the nuns from that province, while the six sisters born in the United States comprised 24% of the subjects born in that country. These findings show that qualifications and merit must have been key factors in selecting candidates. Mastery of the English language may also have been a determining factor, many sisters from Quebec may not have been considered sufficiently fluent in the language to take a position which required frequent contact with governments and provincial representatives.

Longevity

The purpose of this last section is to explore the longevity of the sisters who worked at the EGH and to compare the length of their lives with that of Canadian women. The length of each sister's life was established by using their year of birth and year of death or their year of birth and their age in 1992. Since the exact date and month of birth and death were not recorded, a possible variation of minus one year should be considered for all data reported in this section. Considering this variation, the total possible range is taken into account; being that all sisters could have passed away a day before or a day after their birthday. To avoid compromising the data, the sisters living in 1992 were analyzed separately from the other members of their birth cohort.

Estimates of life expectancy at birth were used to compare the sisters' longevity with the longevity of the general population of Canadian women. In Canada, vital statistics and mortality tables have been computed only since 1921 and 1931 respectively. Recognizing that this made it difficult to study longevity in earlier periods, Bourbeau and Légaré used classical demographic methods and statistical models to establish life expectancy tables for people born between 1831 and 1940.[442]

---

[442] Robert Bourbeau and Jacques Légaré, ***Evolution de la mortalité au Canada et au Québec - 1831-1931***, (Montreal: Presses de l'Université de Montréal, 1982), 110-130; These demographers used logarithmic methods to compute life expectancy of various generations. Each generation is comprised of all people born in a ten year period. For example, all people born between 1921 and 1930 constitute a generation.

TABLE 46

NUMBER AND PERCENTAGE OF BIRTHS BY GENERATION AND LIFE EXPECTANCY AT BIRTH BY GENERATION

Generation	n (%)	Life expectancy
1841-1850	3 (1.44)	43.25
1851-1860	7 (3.37)	44.24
1861-1870	10 (4.81)	45.27
1871-1880	27 (12.98)	47.97
1881-1890	24 (11.54)	51.08
1891-1900	46 (22.11)	53.48
1901-1910	31 (14.90)	58.11
1911-1920	43 (20.67)	62.82
1921-1930	10 (4.81)	67.65
1931-1940	7 (3.37)	70.18
Total	208 (100.00)	

The sisters in this study were born between 1842 and 1938.[443] Results presented in Table 46 indicate the number of births by generation and the corresponding life expectancy at birth.[444] The number of sisters born in each decade reflects the growth of the EGH as well as the time period under investigation. The fact that none of the sisters were born after 1938 is also related to the time frame of this study. However, it may also be linked to the evolution of religious orders in Canada which was a general decline in the number of subjects entering orders after 1940.[445] By 1992, 121 subjects had passed away and 86 were still living.[446] The average age at death for the 121 subjects who passed away before 1992 was 72.84. The standard deviation being 15.31, and the range varying between 26 and 101. The average age of the subjects who were still alive was 80.43 years, with a standard deviation of 10.9 and a range of 54 to 102.

---

[443] Although some of the subjects in this study were not born in Canada, it is believed that because they constitute a small proportion of the population and because they were born in countries with similar life expectancy at birth and that they lived in Canada for a long part of their life that their inclusion in this analysis would not cause significant variations.

[444] Bourbeau and Légaré, ***Evolution de la mortalité***, 110-130.

Results presented in Table 47 show the average age at death and the mean age of subjects alive in 1992 by generation. By 1992, all subjects born between 1842 and 1880 had passed away. Using life expectancy at birth (see Table 46), it is evident that as a group the sisters born in these decades lived significantly longer than was expected for women born in these years. In fact, the raw data indicated that only one subject had a life duration below the estimated norm for her generation. Using other estimates computed by Bourbeau and Légaré it was possible to further compare these nuns with the general population of women born in the same decades. The results presented in Table 48 show the percentage of survivors at age 65 by generation and the estimates established by Bourbeau and Légaré for the same periods of time.[447] Again, it is strikingly apparent that the subjects of this study had very long lives when compared to other women of the same generations.

---

[445] Lessard and Montminy, "The census", 378.

[446] Because of missing information for one subject, the results are based on 208 sisters.

[447] The estimates computed by Bourbeau and Légaré are based on a population of 100,000. Bourbeau and Légaré, ***Evolution de la mortalité***, 60.

TABLE 47

MEAN AGE AT DEATH AND MEAN AGE IN 1992 BY GENERATION

Generation	Passed away Mean age at death (n)	Living in 1992 Mean Age (n)
1841-1850	76.33 (3)	
1851-1860	72.00 (7)	
1861-1870	76.20 (10)	
1871-1880	77.81 (27)	
1881-1890	73.69 (23)	102.00 (1)
1891-1900	73.77 (30)	96.00 (16)
1901-1910	67.83 (12)	86.89 (19)
1911-1920	57.77 (9)	76.23 (34)
1921-1930	49.00 (1)	68.89 (9)
1931-1940		58.28 (7)
N	(122)	(86)

TABLE 48

PERCENTAGE OF SURVIVORS AT AGE 65 BY GENERATION FROM 1841 TO 1880

Generation	Percentage	Percentage estimated (Bourbeau and Légaré)
1841-1850	100.00	36.93
1851-1860	71.43	38.76
1861-1870	80.00	40.64
1871-1880	85.18	44.72

Comparisons are more difficult to make for the subjects born after 1881 because in every generation, at least one subject is still alive. Considering only the subjects who had passed away by 1992, it is apparent that on average those born between 1880 and 1910 lived beyond the projected life expectancy at birth. If those who are still alive are included, the average number of subjects who lived beyond life expectancy at birth becomes even larger. In total, the raw data show that only four subjects born between 1881 and 1910 had a shorter life than expected for their generation. Three of them died in their 20's and one in her late 40's. The cause of death was recorded in the files of two of the sisters who did not reach the age of 30. Significantly, both died from tuberculosis. Results presented in Table 49 show that the percentage of sisters born between 1881 and 1910, who lived beyond 65 years of age was also significantly greater than for the population of women as a whole. The generation born between 1891 and 1900 deserves special attention. If all subjects who were alive in 1992 passed away in 1993, the average age at death for that generation would be 81.85. Thus the subjects of this group will be the first one to live on average more than 80 years.

TABLE 49

PERCENTAGE OF SURVIVORS AT AGE 65 BY GENERATION FROM 1881 TO 1910

Generation	Percentage	Percentage estimated (Bourbeau and Légaré)
1881-1890	70.83	48.98
1891-1900	86.96	52.80
1901-1910	90.32	59.56

A meaningful analysis of the last three generations is more difficult to make because the majority of the subjects were alive in 1992. The results show that the mean age at death of subjects born between 1911 and 1938 was below life expectancy (see Tables 46 and 47). The raw data showed that five of the ten subjects had lived shorter than expected. However, it is obvious that if the subjects who are alive in 1992 are included in the calculations about the generation born between 1911 and 1920, the average longevity would become much higher than estimated. For that generation, all the subjects who are alive were much older than 65 by 1992. In total 86.09% of the subjects of that generation reached that age while the estimate for women of that era is 66.69%.

The results for the generation born between 1921 and 1930 show that only one subject has passed away. She died approximately 18 years earlier than the expected for her cohort. However, average age of subjects alive in 1992 is slightly greater than life expectancy at birth. Since some of these subjects were younger than 65 years of age, the method of comparison based on that factor was not utilized. Finally, considering the youth of the sisters born after 1931, it was considered impossible to evaluate their longevity beyond making the statement that all of them have almost reached the estimated length of life calculated at birth for women of their cohort.

Although it would have been interesting to compare longevity between occupational groups, many factors would have limited the value of such comparison. A comparison that would not have taken into account year of birth would have lead to dubious results. Examining the data within generations was attempted but it was found that sample sizes were too small to permit meaningful analysis.

Lessard and Montminy found that in 1964 the mean age of the nuns who had died that year was 73.8 years.[448] They noted that it was beyond the expected life span of women born that same year. In general, they found that the nuns who had passed away between 1940 and 1960 had longer lives than the expected for women.[449] Therefore the findings of this study are consistent with their results. What are the factors which could explain this seemingly exceptional longevity? The first factor which comes to mind was that most of these nuns would not have had any children. Since childbearing was an important cause of female mortality during a major part of the time period under investigation, not having children may have contributed to longevity. However, the nature of the work of the sisters would have lead to greater exposure to contagious disease than in the general population of women. Nonetheless, because their knowledge of disease transmission and of methods of prevention was greater than in the lay population the sisters might again have been advantaged. Further, their greater exposure to pathogens may have given them opportunities to develop greater immunity. The fact that health services were readily available to them would have also played in their favour. General lifestyle factors were probably determinants as well. These sisters were dressed and fed properly, and even if they did some shift work, they generally had regular schedules which included sufficient hours of sleep. Finally, they did not smoke and drank very little. Considering all of these factors, it is logical that they would have lived longer than other Canadian women of their time.

---

[448] Lessard and Montminy, "The census", 323.

[449] The results they offered were too general to permit formal comparisons with my the sample of this study.

In conclusion, the results presented in this chapter showed that while the backgrounds of the Grey Nuns who worked at the EGH were diverse, many of the common traits were predominant in the entire population. It is suggested that these characteristics would have contributed to cohesion and facilitated the development of an *esprit de corps*. Findings presented in other chapters show how these traits came into play in shaping the spirit of the group. For example, the French Canadian roots of many sisters influenced the order's involvement in the local Franco-Albertan community, and lead to the preservation and honouring of a number of traditions. Similarly, many of the values which were emphasized in the daily functioning of the hospital and in the sisters' communal life were similar to those commonly seen in large families.

CHAPTER 12

THE WORKFORCE OF THE EDMONTON GENERAL HOSPITAL.

The purpose of this chapter is to examine issues related to the hospital's workforce. Attention is given first to the evolution of this workforce in terms of magnitude and diversity, and then to a discussion of benefit packages and the development of collective bargaining. Finally, the shift from a family like atmosphere to a more impersonal *milieu* is explored. The data presented in this chapter comes from five main sources of documentation. The demographic data gleaned from the Grey Nuns' personal files provided information on the occupation of each sister and facilitated the determination of how many sisters worked at the EGH on an annual basis. Data about lay employees was found in the annual reports of 1913 to 1967. These reports provided the total numbers of employees and some details about their distribution by fields of work. The chronicles of the EGH and the papers of the Board of Directors included material about labour relations and the hospital as a work environment, while the minutes of medical staff meetings provided helpful information about medical students and practitioners.

Evolution of the hospital workforce

The EGH has emerged from a small hospital with few employees in the 1890's to a complex institution and a substantial employer in the 1970's. The growth of the workforce in terms of magnitude and diversity demonstrates how much the hospital had changed over the period of time under investigation. In order to facilitate analysis, some of the data in this section is presented using the five time periods which were utilized to examine the hospital's administration. In addition, the evolution of the Grey Nuns' workforce is addressed separately and is followed by a specific examination of the lay workforce.

The Grey Nuns

Duration of hospital service by the Grey Nuns

Using the personal files of each sister it was possible to determine how many years each individual spent at the EGH. The mean number of years worked at the EGH was 5.8 years (s being 7.4). Results presented in Table 50 show the number of sisters by the number of years worked in the institution. Five sisters worked more than 25 years; 26 years (a nurse), 30 years (nurse and technician), 33 years (nursing aide) and 56 years (laundry department worker). The most frequent categories for tenure at the EGH were: one year (41 subjects), 2 years (29 subjects), 3 years (24 subjects) and 6 years (21 subjects). Results presented in Table 50 show that 178 sisters or 85.1% of the sample spent less than eleven years at the EGH. It must be noted that the results of Table 50 represent the total number of years at the institution and do not take into account the continuity or discontinuity of these years. At times, sisters who had left the institution were brought back for another term of several years duration. Mobility was observed in all occupational groups; however, significant differences between occupations could not be established.

TABLE 50

NUMBER OF SISTERS BY RANGE OF NUMBER OF YEARS WORKED AT THE EGH

Range of years	n	(%)
1 - 5	124	(59.3)
6 - 10	54	(25.8)
11 - 15	19	(9.1)
16 - 20	6	(2.9)
21 - 25	1	(0.5)
26 - 30	3	(1.4)
31 - 56	2	(1.0)
Total	209	(100.0)

Sisters in leadership positions were also transferred on a regular basis. Undoubtedly, this was a healthy practice since it allowed for the transfer of new ideas within the network of Grey Nuns hospitals. Results presented in Table 51 show the number of years that superiors and directors spent in these roles. The average number of years worked by superiors was 4.7 years (s being 2.1), while the mode was six (four subjects). On average, directors held their positions for similar lengths of time as the superiors. However, for directors, the standard deviation was 3.1 and the mode was three years (five subjects). The arrival of a new superior did not necessarily meant a change of director. In fact, no patterns could be discerned, except that during the superiorate of the sister who was in place for nine years the school of nursing had only two directors, one of whom was in charge for seven years. Within the directors' group, it was found that between 1926 and 1943, all directors were appointed for three years (except in 1936-37 when a sister was temporarily appointed).

It is of interest that, prior to their nomination, three of the superiors held other positions at the EGH, while two others did so after the completion of their mandates as superior. Thus only five of the thirteen superiors held other positions at the hospital. In contrast, this was the case for nine of the thirteen directors. Four directors worked at the EGH prior to becoming director, two worked there after having been director, while three worked there before and after the completion of their mandate.

TABLE 51

NUMBER OF YEARS SPENT IN LEADERSHIP ROLES

Number of years	n of superiors	n of directors
1		1
2	3	1
3	3	5
4	2	1
5	1	2
6	4	
7	2	
8		1
9	1	
10		1
11		1
Total	16	13

Sisters' occupational diversity through time

The number of occupations in which the sisters were engaged increased over time. It is evident that the appearance of new occupations can be linked to technological changes. The results presented in Table 52 show the number of years for which occupations were represented and the first year when a sister from each given field arrived at the EGH.

TABLE 52

SISTERS' OCCUPATIONAL DISTRIBUTION THROUGH TIME

Occupation	no. of years for which each occupation is represented	year of arrival of the first member of this group
Nurse	75	1895
Labourer	75	1895
Office worker	52	1904
Nursing aid	43	1920
Medical archivist	34	1932
Lab./X Ray tech.	30	1935
Sacristan	26	1909

Until 1904, all sisters were either nurses or labourers such as cook, seamstress and laundry worker.[450] Beginning that year office work assumed the status of a separate occupation and by 1935, the full range of occupations was found in the records. That sisters specifically educated as technicians came to the EGH in the 1930's, can be linked with the increasing complexity of technical work. In addition, as diagnostic testing became more generalized, nurses would not have had enough time to continue to fulfil the demands in this area.

A new occupation which was created in the 1950's is not presented in Table

---

[450] These results must be looked at with caution. As explained in the previous chapter, sisters often cumulated more than one role. However, the results of this section are a good indicator of increasing specialization.

52.[451] In 1956, a sister was assigned to pastoral care, position she held until 1967. She appeared to have been the first individual to play this role at the EGH.[452] Not shown in the results presented in Table 37 is that occupational diversity had reverted by 1968 to almost what it had been in the 1890's. From 1968 until 1970, the only occupations which were listed in the records were these of nursing, labourer and sacristan. It is suggested that this can in large part be explained by the decrease in the number of sisters who worked at the EGH during the 1960's. In turn, this decrease was probably linked the diminution in the number of religious vocations in Canada as well as to the changes which took place in the administrative structure of the hospital.

TABLE 53

STATISTICS ON THE NUMBER OF SISTERS BY TIME PERIOD

Period of time	$\bar{X}$ number of sisters	Range
1895-1904	9.5	7 - 11
1905-1918	11.6	9 - 18
1919-1938	18.9	17 - 22
1939-1957	21.8	18 - 28
1958-1970	18.5	26 - 8

The results presented in Table 53 show the variation in the number of sisters who worked at the EGH between 1895 and 1970. The average number of sisters who worked at the EGH grew until the end of the 1939-1957 time period. The raw data indicated that in 1957 there were 27 Grey Nuns at the hospital. Following 1957, there was a gradual decline leaving only 8 sisters in 1970. It must be noted that even if the number of sisters had increased during most of the years under study, the rate of growth did not match the growth of the institution. For example, in 1895 there were 7 sisters for 36 beds, while by 1920, when the number of beds had reached 200, there were only 17 sisters in the institution.

---

[451] The sister who held this occupation was classified as a nursing aide.

[452] Pastoral care will be addressed in a chapter on the catholic nature of the EGH.

Examining the progression in the number of sisters by occupation, it was found that the nursing subset was the only one in which significant variations in size were found over time. The maximum number of nuns who were nurses was reached in the period spanning from 1919 to 1939. In 1928 and 1929 there was a record number of fifteen nursing sisters. After 1939, the number of nuns who were nurses remained fairly stable (between 10 and 13) until this figure began to drop in 1960. By 1970, there were only four nuns who were nurses. It is relevant to mention that the first lay nurses were hired in 1928 and that from 1938 onwards they were always more numerous than the nursing sisters.

Labourers never numbered more than five in any given year, and the number of sisters in all other occupations was never greater than three. Between 1895 and 1957 the number of nuns increased in a gradual manner and the addition of new wings did not seem to lead to immediate increases in the number of sisters. Significantly, the largest ratio of nuns per lay employees was found during the first decade of the hospital's operation. Although the number of sisters was always small, these nuns consistently assumed leadership positions of considerable responsibility. This was particularly the case for the nuns who were nurses. Most of them were either hospitaller[453], supervisor, assistant superior, director or superior. Considering that nuns who were technicians were also in charge of their departments, it appears that most leadership positions related to patient care were filled by members of the order.

Lay staff

Prior to 1913, little data was maintained about lay employees. The only comments concerning lay staff which could be identified were found in the chronicles. Based on this source, it appears that these employees had support roles. There were a few female servants and some hired men who took care of the hospital grounds and of the farming activities. The exact number of employees could not be determined because data was incomplete. However, from 1913 to 1967 the annual reports provided details about lay personnel. From 1913 to 1924 these reports included the number of sisters, nursing students and lay employees. Interns were counted from 1925, graduate nurses from 1928, and registered pharmacists from 1929 onward. This occupational distribution remained unchanged until 1952. However, from 1936 onward, the information about support staff included a count of female and male employees. Finally, from 1952 until 1967 records were kept on the number of dieticians, female and male office workers, laboratory technicians and students, nursing assistants, medical archivists and students, salaried physicians, and radiology technicians and students. Data of the late 1960's also included some information about part-time workers.

---

[453] The term hospitaller was used the designate the head nurse of a department.

It is evident in this very general overview that specialization increased over time. Results presented in Table 54 consist of statistics on the hospital workforce between 1913 and 1967. They include the range and the average number of staff including sisters and lay employees. The same information but also including nursing students is provided in Table 55, while results presented in Table 56 include all other students (interns and students in technical fields). The results presented in these three tables provide a clearer picture of the evolution of staffing at the EGH. Comparing the results presented in these tables it is apparent that nursing students constituted an important component of the workforce, while other students represented a small proportion of the overall staff. It is believed that the figures found in the annual report were probably fairly accurate. However, it was noted that the number of physiotherapists was never reported. Including them would not have significantly changed the results since they never seemed to number more than two. The 1960's saw the development of a part-time workforce. In 1964, 47 nurses worked part-time. It appears that they were the only part-time employees of the hospital. However, by 1967, a small number of male and female support staff also worked part-time: 30 out of 110 workers. The introduction of this new type of schedule may have been in response to the staff shortages which characterized those years.

TABLE 54

STATISTICS ON EGH STAFF INCLUDING LAY EMPLOYEES AND NUNS BY TIME PERIOD

Period of time	$\bar{X}$ number of staff	Range
1913-1918	29.6	26 - 31
1919-1938	74.0	37 - 115
1939-1957	277.7	128 - 524
1958-1967	597.2	558 - 697

TABLE 55

STATISTICS ON EGH STAFF INCLUDING LAY EMPLOYEES NUNS AND NURSING STUDENTS BY TIME PERIOD

Period of time	$\bar{X}$ number of staff	Range
1913-1918	57.0	46 - 48
1919-1938	147.2	73 - 182
1939-1957	411.1	189 - 699
1958-1967	763.4	733 - 799

TABLE 56

STATISTICS ON THE EGH STAFF INCLUDING EMPLOYEES NUNS AND ALL STUDENTS BY TIME PERIOD

Period of time	$\bar{X}$ number of staff	Range
1925 - 1938	165.6	151 - 187
1939 - 1957	468.3	195 - 701
1958 - 1967	813.3	779 - 872

Nursing staff

If nursing students are included in the nursing workforce, nursing staff was consistently the largest group of hospital employees. The second largest group consisted of support workers. Interestingly, until 1938, the number of nursing students was always greater than the number of support workers. However, registered nurses were always less numerous than the latter. Results presented in Table 57 provide details about the mean numbers of student nurses, nurses, nursing aides and support workers.[454] The results clearly show the numerical importance of nursing students. It is only in the last period of time that the number of nurses became greater than the number of students. However, the development in the 1960's of a part-time nursing workforce must be evaluated in order to understand the evolution of nursing staffing. In 1964, 47 of the 187 nurses worked part-time, while in 1967, 110 of the 285 nurses had part-time schedules. It is thus apparent that the increase in nursing personnel cannot be taken at face value.

TABLE 57

COMPARISON OF THE NURSING AND SUPPORT STAFF WORKFORCES

Period of time	$\bar{X}$ SN	$\bar{X}$ RN	$\bar{X}$ NA	$\bar{X}$ All Nsg	$\bar{X}$ SS
1913-1918	27.4			27.4	16.0
1919-1938	73.1	6.5		76.9	52.2
1939-1957	133.4	62.0	6.5	197.6	185.0
1958-1967	166.2	190.5	56.0	412.7	295.1

Abbreviations used: Nursing Students (SN), Registered Nurses (RN), Nursing Aids (NA), Support Staff (SS). The first RN was hired in 1928 and the first nursing aide in 1952.

The proportion of nursing personnel in the total workforce remained fairly stable over time. From 1913 to 1918 they comprised 59.8% of the total, 53.8% between 1919 and 1938, 44.7% from 1939 to 1957, and 52.9% from 1958 to 1967. It is suggested that the drop in proportion of the nursing personnel between 1919 and 1938 may be in large part attributed to the economic conditions which prevailed in some of those years.[455] Prior to the late 1920's there were normally some 95 nursing students at the hospital, while during the early thirties this figure dropped to around 75. The ratio of beds per nurse (including nursing students) was also fairly stable. It was 2.2 beds per nurse for the years 1913 to 1918, 2.6 between 1919 and 1938, 2.2 between 1939 and 1957 and 1.2 between 1958 and 1967.[456] Although this data provide some numerical information about the nursing workforce the issue of the *quality* and the preparation of these care givers are not addressed. Indeed, while the proportions may have been stable the type of nursing personnel varied considerably. The role given to nursing students changed a great deal during the 75 years under study. However, it is reasonable to suggest that students constituted an essential component of the workforce especially prior to the 1960's.[457] Until 1928, the only registered nurses were Grey Nuns most of whom occupied leadership positions. Similarly, the first nurses who were hired were often given supervisory and teaching positions. After World War II, however, the number of registered nurses increased dramatically. As time passed, as patient care became more complex and as concerns about nursing education were raised in a series of reports, it became evident that professional nursing care was not a luxury, but a critical and essential component of hospital care.

---

[454] Grey Nuns who were nurses are not included in the results of this Table.

Data about the nurses who worked at the EGH was limited. In general, issues relating to the nursing staff were raised when collective agreements were under review or when shortages of nurses interfered with patient care delivery.[458] The first shortage of nurses was alleviated by the creation of a school of nursing in 1908. According to Sr Ell, the school was born "... because the number of nuns was never quite enough."[459] Shortages of nursing students and of nurses became a recurring concern in subsequent years.

---

[455] The drop was also related to the large number of tuberculosis beds. This topic is further addressed in the chapters on the school of nursing and on the administration of the hospital between 1919 and 1938.

[456] Based on the maximum number of beds for each time period. Chronologically the number of beds were: 60, 200, 434 and 500.

[457] More information about student nurses is provided in the chapter on the school of nursing.

In 1926, the chronicles revealed that the physicians believed that the number of nurses assigned to the night shift was insufficient.[460] Despite this, it seems that the *status quo* prevailed until three lay nurses were hired in 1928. According to the chronicles the insufficient number of nuns had forced the Order to hire lay nurses, far from an ideal situation because it would increase the hospital's operating costs.[461] There is evidence that after 1933, graduate nurses were assigned to leadership positions. For example, one nurse was hired to teach in the school of nursing and another was employed as the night supervisor of an entire floor.[462] Of interest, these two nurses were not graduates from the EGH school of nursing. Thus, it can be suggested that the sisters evaluated graduates from other institutions and concluded that they could adapt to the work requirements of the EGH.

The first nationwide shortage of nurses occurred during World War II.[463] Provincially, the Alberta Association of registered Nurses (AARN) and the Associated Hospitals of Alberta (AHA) proposed that the creation of a central school of nursing might contribute to solve the issue.[464] This idea remained on the agenda during the postwar years. However, such a school was never created. The Grey Nuns were among the many who opposed the plans. It may be have been that they feared a central school would not be able or willing to transmit Roman Catholic values. During the war, nursing professional associations took specific measures to alleviate the shortage of nurses, measures which were primarily related to the recruitment of potential students. In particular, the Canadian Nurses Association (CNA) developed a booklet which was used for that purpose. In 1941, the AARN took the initiative to secure a nurse whose role was to visit all high schools in the province to recruit potential students.[465] The same year the EGH invited the students in Catholic high schools to visit the hospital. The goal was to attract more students, specifically Catholic ones.[466] Unfortunately, the shortage continued and the situation did not improve in the postwar years.

---

[458] Collective bargaining is fully addressed in the last section of this chapter.

[459] ASGME, Sister Ann Ell, "Edmonton General Hospital Research: 1895-1985", (Edmonton: unpublished document), 29.

[460] ASGME, EGH, Chroniques, 26 November 1926.

[461] Ibid., 1928.

[462] Ibid., 1933.

[463] A dozen of student nurses were enrolled after completion of their studies. ASGME, Ell, "Edmonton General", 49.

In 1949, the EGH purchased a house located on 112 street.[467] The Sisters had two goals in mind. By purchasing this property, additional living quarters would be available for nursing students, and would made it possible to increase enrolment; also by increasing the number of students, it would be possible to decrease the number of graduate nurses they needed to hire.[468] From an administrative point of view, this was a win/win situation. Nursing students could take the roles of registered nurses if these could not be found, and further, they could decrease the need to hire registered nurses by providing a bigger student workforce. It is also clear that students were still perceived as staff, or staff replacements, and that the hospital did all it could to control costs by hiring the smallest possible number of registered nurses.

---

[464] Donald Juzwishin, "A history of the Alberta Hospital Association, 1919-1970", (Health Sciences Administration master's thesis, University of Alberta, 1980), 68.; the Associated Hospitals of Alberta changed name to the Alberta Hospital Association in 1966; Joy M. E. Myskiw, "The influence of the Alberta Association of Registered Nurses on health care services and health care policies from 1916 to 1950", (Nursing master's thesis, University of Alberta, 1992), 142.

[465] Myskiw, Ibid., 137.

[466] ASGME, EGH, Chroniques, 1941.

[467] One block away from the hospital.

[468] ASGME, EGH, Chroniques, 1949.

This plan must not have had the expected effect, since in 1953 the shortage of nurses continued to be acutely felt. In fact, the opening of a new wing was postponed of a few months because nurses could not be found.[469] Obviously young women were choosing other fields than nursing in which to pursue careers. Throughout the 1940's the professional associations had claimed that difficulties in attracting students would continue as long as work conditions were poor.[470] When the AHA suggested that the hiring of nursing assistants would relieve nurses from non-professional duties, nurses believed that there was recognition of the problem by the hospitals' association.[471] The EGH must have shared some of the AHA's views since the first nursing assistant was hired in 1952.[472] However, it would seem legitimate to suggest that hospital administrators had conceived a new way to decrease nursing costs rather than a way to improve working conditions of nurses. The Catholic Hospital Association of Alberta (CHAA) was also concerned by the shortage of nurses. In 1953, the executive committee of the association spent an entire day discussing the topic. It was even decided that the bishops would ask all priests to talk about nursing in the homily of the Sunday mass closest May 12.[473] Obviously, even Florence Nightingale had to be used to shore up recruits to nursing!

---

[469] Ibid., 1953.

[470] Myskiw, "The influence of the Alberta Association", 137.

[471] Juzwishin, "A history of the Alberta Hospital Association", 102.

[472] ASGME, EGH, Annual Report 1952; The preparation of the nursing assistants who worked at the EGH could not be determined. It can be suggested that the hospital probably followed the trends and that after 1960 most nursing assistants must have been registered nursing assistant.

[473] Sr Thérèse Castonguay, ***A mission of caring: Catholic Health Association of Alberta. A chronicle of the first fifty years***, (Edmonton: Catholic Health Association of Alberta, 1991), 28; The Catholic Hospital Association of Alberta became the Catholic Health Association of Alberta in 1987, Ibid., 151.

Yet, the shortages continued throughout the 1950's and 1960's and the hospital continued to organize visits for high school students.[474] Importantly, it was during these years that nurses began to be allowed to continue to work after their marriage.[475] In addition, it seems that the hospital had started to accept the idea it would not be able to rely as much as it had on the work accomplished by the nursing students. In 1957, it was reported in the chronicles that fifteen registered nurses had been hired, that they were more then welcome and that "there was always plenty of work to be done."[476] In 1963, the hospital trained nineteen registered nursing orderlies, a category of worker which was the male counterpart of the female registered nursing assistant.[477]

By 1970, the problem shortages of nurses had not been solved and the creation of specialized units was exacerbating the problem. In particular, nurses willing and able to work in the intensive care unit were hard to find.[478] It is interesting to note that until then shortages of nurses had always been seen in terms of numbers. For the first time, the issue was specifically linked with skills required for the provision of specialized care.

In summary, the availability of nursing staff was a constant concern at the EGH, as it was in other hospitals of the country. Nursing students were used as an essential component of the workforce and financial constraints were often cited to justify this practice. Because the EGH was operated by a religious order, the presence of nuns who were nurses allowed the postponement of hiring lay nurses. However, because the sisters were never numerous, this advantage existed only during the early years of operation and could be seen as marginal. The continuous growth of the hospital, changes in nursing education and the increasing complexity of nursing and medicine created new needs that necessitated the presence of more registered nurses.[479]

---

[474] ASGME, EGH, Chroniques, 1955 to 1969; In the summer of 1967, some units even had to be closed down because of the shortage of nursing staff. ASGME, Minutes of the Board of Directors (MBD), July 1967 and Minutes of the medical staff meetings (MMSM), 2 August 1967.

[475] Until the 1960's most hospitals refused to keep married women on staff and such a regulation was in force at the EGH. The exact time at which a significant number of married nurses were allowed to continue to work could not be determined. However, in 1955, the chronicles reported that one of the hospital engineers had married a graduate nurse from the EGH school of nursing and that she would remain on staff. ASGME, Chroniques, 1955.

[476] ASGME, EGH, Chroniques, 1957.

[477] ASGME, EGH, Chroniques, 1963. It would have been interesting to find more about these men but data was not available. In particular, it was impossible to determine how many of them found employment at the EGH.

[478] ASGME, EGH, MMSM, 2 September, 1970.

In general, it seems reasonable to suggest that shortages of nurses were more the product of administrative practices and governmental attitudes towards hospital funding, nursing and nursing education than to real shortages. By relying on a nursing student workforce and by offering low wages to registered nurses, hospitals created the false impression they could operate within the grants or the budgets they were given at the time. It is suggested that if at inception wages had been set at respectable levels, governmental allocations might have been more generous. For example, the federal government of the 1890's may have given more than one dollar a day to cover the cost of hospitalizing immigrants. One might also speculate that if nurses had been men, conditions would have been different and hospitals would probably have been given larger budgets.

Sexism was definitely a central element of nurses' problems and of the resulting nursing shortage. Hospitals supposedly could not afford to give better wages to nurses, yet they could give advantageous conditions to male employees with less qualifications.[480] The EGH was part of a society in which the work of women was devalued. Even if the sisters had wanted to give nurses better wages, it would have been difficult because the government assistance would not have increased proportionately; in order to remain competitive, the EGH could not have contemplated raising the hospital's fees in order to support higher wages. Changing the nurses working conditions required a global change in society.[481] Still, one might ask why female religious orders were not more vocal about the double standard that existed in society and in their own institutions. It is believed that the sisters were similar to other women who lived during the era; they too were pressured to "keep their place."[482]

---

[479] The topics are further addressed in the chapters on the school of nursing and patient care delivery.

[480] See the subsection "The double standard".

The regulations which forbade married nurses to work contributed to the illusion of shortages. The net result of this administrative practice reached a peak after 1945 when marriages and childbirth increased due to the cessation of hostilities and the return of peaceful conditions. New graduates chose to be married, thus further diminishing the pool of available subjects. It is unlikely that many young mothers would have been able to maintain their position in the workforce; again this was not approved by society. However, it is probable that many of those who postponed childbirth might have continued to work if this had been an acceptable option; in so doing they would have contributed to reducing the shortage of nurses.

In the 1950's and 1960's, a new element emerged in the shortage issue. Women began to be able to select a number of careers that had been closed to them until then. Hospitals complained that not enough young women were interested in becoming nurses. Yet, willingly or not, they had created part of the problem. If hospitals had given nurses higher wages and better working conditions, it is likely that more students would have been attracted to a nursing career. Hospitals had also chosen to use nursing students as employees and as the main providers of care. It is suggested that this practice was sexist and was clouded by administrative considerations. Such a practice created an artificial demand every time a new class graduated; therefore, anxiety about having enough students enrol was consistently a thorny issue. The success of this system was dependent on societal prescriptions that kept the number of careers available to women as low as possible. When the male vision of the world began to be challenged hospitals and governments were faced with the consequences of their longstanding policies. The absurdity of relying on nursing students as a work force is best demonstrated by transposing the model to society as a whole. Imagine a society in which the entire workforce would consist exclusively of students. Roughly, this would mean that those between 18 and 25 years of age would offer all services and produce all goods. Based on numbers alone it is evident that this age cohort would not be able to satisfy the needs of all other cohorts. It is suggested that a model relying on nursing students as the most important component of the nursing work force was soon or later bound to fail. The failure came when the supply of nursing students became lower than the number of nurses required to staff a modern hospital.

---

[481] There is still ample evidence that this change is far from complete in the 1990's.

[482] The expression "rester à sa place" (translated by keep their place) was commonly used in French Canada until the mid-1960's. It meant that women should not transgress the rules which were and had to be set by men.

In reviewing both the effects of this artificial shortage and the growth of the Canadian hospital system, it is not surprising that the authors of the Report of the Royal Commission on Health Services concluded that Canada would need 20,000 more nurses by 1971.[483]

Support staff

Nurses were not the only large group of women working at the EGH. Results presented in Table 58 show that the hospital increasingly counted on women to offer support services. Indeed, between 1936 and 1938, the number of male and female employees was almost equal, while between 1958 and 1967 there were almost three times more women than men in support occupations. Shortages of support staff were rarely mentioned in the records. The only period of time for which such shortages were reported (mostly a shortage of men) was during World War II and in the immediate post-war years.[484] In 1939, the support staff included 34 men and 51 women, while by 1945 the numbers had changed to 36 and 114 respectively. It was only after 1953 that the number of men rose above 70. Interestingly, it seems that a new pattern was set during

---

[483] Government of Canada, ***Report of the Royal Commission on Health Services***, Volume I, (Ottawa: Queen's Printer, 1964), 548.

[484] ASGME, EGH, Chroniques, 1944 and 1948.

World War II, and from then on the number of women employees was always greater than the number of men. Did women take over positions that had previously been occupied by men? Was the increase related to the shortage of nursing staff? There is evidence to suggest that both questions can be answered affirmatively. For example, prior to WWII the position of hospital switchboard operator had been held by a man, while after the war women were commonly used in that type of work. The shortage of nurses may also have resulted in the hiring of support staff who could assist with some aspect of patient care such as providing assistance at meal times. In general, the employers may have considered that since women could be given lower salaries, hiring them would constitute a sound cost control measure. The fact that women were less active in the union movement, may have also made them more attractive to the employer.

TABLE 58

MEAN NUMBER OF SUPPORT STAFF BY GENDER AND BY TIME PERIOD

Period of time	$\bar{X}$ number of men	$\bar{X}$ number of women
1936-1938	30.0	43.3
1939-1957	47.2	137.8
1958-1967	77.2	217.9

However, in the 1950's and 1960's the increasing number of secretarial positions contributed to most of the growth in the number of female employees. In turn, it may be suggested that the creation of a large number of office positions (primarily secretarial ones) in the 1950's and 1960's was linked to the implementation of state controlled hospital insurance. The new plan required more sophisticated methods of accounting and budgeting; consequently, an army of office workers had to be put in place. In 1952, there were 30 women and two men classified as office workers, by 1967 this category of employment included 65 women and 6 men, with the men in the supervisory positions.[485] This was the time during which the sisters transferred a great deal of the administrative responsibilities to hired men. In itself, this transfer of duties to male employees probably created a need for additional secretarial staff. It is reasonable to suggest that these employees would not have worked as long hours as the sisters; hence the need for support services would have been greater.

Technical workers

Although they were always a small group, technical workers offered essential hospital services. The rising number of technicians was directly linked with the development and sophistication of diagnostic tools. In 1920, the hospital opened its first X-Ray and laboratory department.[486] Prior to that time laboratory procedures had been performed on nursing units and the hospital had functioned without any radiology equipment.[487] The opening of this department led to the hiring of the first two salaried physicians. A full time pathologist was hired, while a radiologist served on a part-time basis.[488] During its first years of operation the department was operated and staffed by one Grey Nun. In 1938, the hospital opened a school whose mission was to prepare radiology technicians, and ten years later a laboratory technical program was initiated.[489] Although these schools were very small as compared to the nursing school they too were created to ensure a supply of workers. The students in these programs constituted a readily available workforce and staffing ratios confirmed the use of students as workers. The number of radiology technicians remained stable throughout the 1950's and the 1960's, while the number of students in the field greatly increased.[490] In 1952, there were four X-Ray technicians and five students. In contrast, in 1967 the number of technicians had increased to six and the number of students to twelve.[491] The growth in the number of laboratory technicians was much more important. It went from five in 1952 to 25 in 1967. During the same years there were 9 and 14 students. However, it must be noted that the school had 25 students in 1963 and 30 in 1964.[492] In general, it does not seem that the hospital suffered from technician shortages. However, in 1944, a shortage in the number of radiology technicians pushed the hospital to ask a newly married technician to remain on staff.[493] This shortage was probably linked to the war effort. Considering that orthopaedic injuries were common on battlefields, it seems logical that radiology technicians would have been in great demand. In 1955, the hospital opened a school for medical record librarians.[494] The total number of students ranged between three and ten a year.[495] During the same period of time the number of medical record librarians grew from two to five.

---

[485] However, these men had adequate qualifications.

[486] ASGME, EGH, Chroniques, 1920.

[487] According to Sister Ell, the EGH was the first hospital in Canada to offer radiology services. ASGME, Ell, "Edmonton General", 55.

[488] ASGME, EGH, Chroniques, 1921; The first full time radiologist was hired in 1951; ASGME, EGH, MMSM, 19 June 1951.

[489] The laboratory school was the first one in Edmonton. Both schools were headed by Grey Nuns. ASGME, EGH, Chroniques, 1938 and 1948.

Pharmacists, dieticians and physiotherapists

These professionals always comprised a very small proportion of the hospital workforce. The first registered pharmacist was hired in 1929, prior to that time pharmacy had been part of nursing responsibilities. The search for the first pharmacist was the result of a new provincial legislation which made the hiring of a registered pharmacist compulsory.[496] Interestingly, it was only after 1962 that the EGH constantly had two pharmacists on staff; a third was added in 1966.[497]

---

[490] Information concerning the years prior to the 1950's could not be found.

[491] ASGME, EGH, Annual reports, 1952 to 1967.

[492] Ibid.

[493] ASGME, EGH, MMSM, July 1944.

[494] ASGME, EGH, Chroniques, 1955. Sister M.P. Rheault who held a diploma in the field was named director.

[495] ASGME, EGH, Annual reports, 1955 to 1967.

[496] ASGME, EGH, Chroniques, September 1928.

The first two dieticians were hired in 1947. Their hiring was directly related to recommendations in the accreditation report of that year. The American College of Surgeons had urged the sisters to hire a professional dietician.[498] Again nurses had operated dietary services until that time. After 1952, the hospital employed between three and four dieticians.

The first physiotherapist joined the hospital staff in 1941.[499] The duration of employment of this individual could not be determined. However, she was no longer on staff when the first department of physiotherapy was created in 1948.[500] At that time a new physiotherapist was hired. Significantly, the first two therapists were graduates from the University of Toronto, the first university to offer physiotherapy diplomas in Canada.[501] Of interest, the chronicles revealed that prior to the arrival of a the therapist in 1948, radiology technicians had provided physical therapy treatments. They soon returned back to this practice since the new physiotherapist left the hospital only three months after her arrival.[502] The reasons for her departure could not be identified. It is clear that she had been replaced by 1952, since the chronicles revealed that a second physiotherapist was hired because of the special needs of *polio* patients.[503]

---

[497] ASGME, EGH, Annual reports, 1929 to 1967.

[498] ASGME, EGH, MMSM, American College of Surgeons (ACS) to Sr Superior, 20 January, 1947; Sr Superior to ACS, 15 april 1949.

[499] ASGME, EGH, MMSM, 1941 (precise month unknown).

[500] ASGME, EGH, Chroniques, March 1948.

[501] The University of Toronto offered its first course in 1929. The second program was started at McGill University in 1942, while the University of Alberta created a third program in 1954. Robin S. Harris, ***A history of higher education in Canada, 1663-1960***, (Toronto: University of Toronto Press, 1976), 415, 541.

[502] ASGME, EGH, Chroniques, March 1948 and June 1948.

[503] ASGME, Ibid., July 1952.

Physicians, interns and residents

Although most physicians were not hospital employees their services were essential to the hospital and the growth of this group of professionals is of interest. In 1895, there were 5 physicians practising at the EGH. By 1965, the number of staff men had increased to 83. If the physicians who sporadically practised at the EGH were included in the total the number would be in the order of 300.[504] The rise in the number of physicians can be attributed to the growth of the EGH, the development of medical knowledge and increasing specialization in medicine. In 1895, physicians were either general practitioners or surgeons. By the end of World War II, specialists were common, and in 1948, dermatologists, EENT specialists, general practitioners, general surgeons, neurology specialists, obstetricians/gynaecologists, orthopaedic surgeons, pathologists, paediatrician, psychiatrists, radiologists and urologists admitted patients at the EGH.[505]

In 1924, the EGH established its first linkage with the University of Alberta by providing clinical experience for a medical student. Four years later, interns began to practice at the hospital.[506] Between 1928 and 1967 the number of interns ranged between none and seventeen a year.[507] The availability of interns was greatly reduced during World War II. None were listed in the annual reports of these years. The minutes of the medical executive committee of April 4, 1944, revealed that all interns were claimed by the armed forces.[508] It was not possible to determine when the EGH hired its first resident. However, it is certain there was one in 1953.[509] During the 1950's interns continued to be in short supply and a shortage of physicians seemed to exist until the late 1960's.[510] Shortages of physicians were common nationwide and in concert with their recommendation about the supply of nurses, the writers of the Royal Commission on Health Services suggested that the country needed more medical practitioners.[511]

---

[504] ASGME, EGH, Chroniques, 1895; MMSM, Medical Report, December 1965.

[505] ASGME, EGH, MMSM, 1948.

[506] ASGME, EGH, Chroniques, 1924 and 1928; Official affiliation with the University of Alberta started in September 1935. Ibid., 1935.

[507] ASGME, EGH, Annual reports, 1928 to 1967.

[508] ASGME, EGH, Minutes of the medical executive committee (MMEM), 4 April 1944.

Chaplains

As a Roman Catholic institution the EGH was assigned a chaplain by the local diocese. The services provided by this clergyman are briefly addressed when the religious nature of the institution is discussed.

Collective bargaining

Collective bargaining became a constant issue towards the end of the second world war. Prior to this time formal contracts regulating the employee/employer relationship were uncommon at the EGH. In fact, only one contract was found in the entire archival material covering the years from 1895 to 1948. This contract was signed by the boiler engineer in 1921.[512] The fact that the year was 1921 is revealing because it suggests that the formalization of the relationship between this employee and the institution may have been related to labour unrest which took place in Edmonton in 1919. In May of that year, 2000 workers in Calgary and Edmonton walked out to support Winnipeg workers who were in the midst of a general strike. The Winnipeg conflict had arisen because building and metal workers were requesting the right to collective bargaining.[513]

---

[509] ASGME, EGH, MMSM, 1953.

[510] ASGME, EGH, MMSM, 1955 and 1966. Topic continuously discussed throughout.

[511] Government of Canada, ***Report of the Royal Commission on Health Services***, 69.

[512] ASGME, EHH, Doc. 106A. Memorandum of agreement made this twenty-first day of July, A.D. 1921.

[513] Palmer and Palmer, ***Alberta a new history***, 191.

Although it does not appear that any EGH employee joined the strike movement, nevertheless it was nine months later that an approach was made to the hospital by the *Canadian Brotherhood of Stationary Engineers and Firemen* to organize a labour union. In February 1920, the hospital lawyer informed the superior that the hospital engineer and driver were obliged to subscribe to the conditions of employment which had been set by the institution and that hospitals were not bound by the *Factory Act*.[514] The following April, the secretary of the aforementioned union informed the hospital that engineers should be paid between $140.00 and $185.00 a month and that according to their seniority, they should be granted from one to two weeks of annual vacation.[515] In May, the same individual requested that a decision be made regarding the contract of the engineer.[516] No further correspondence could be found. However, it appears that the engineer did not join the union. Instead, in July, he signed a contract offered by the hospital. The document had three clauses. In clause one it was stipulated that the employee agreed to "serve" the EGH "faithfully, honestly and diligently" and that he agreed to "comply with all rules and regulations made under the Boiler's Act of the Province of Alberta." The object of the second clause concerned his salary which was set at $140.00 a month. Finally, it was specified in clause three that fifteen day's notice was necessary to terminate the agreement.[517] It is notable that the engineer's salary was in line with the proposed scale of the aforementioned union. However, the contract did not include any clause regulating annual vacations.

A climate leading to collective bargaining

In 1944, the federal government gave its employees collective bargaining rights by passing the *Labour Relations Act*. It is suggested that the adoption of this law had a far reaching effect by stimulating the growth of the collective bargaining movement in many fields of industry and of the service sector.[518] The second world war was also affecting Canadian hospitals. "The mobilization of nurses and the availability of war work for other employees disrupted the traditional staffing system whereby hospitals had been guaranteed a stable and compliant workforce."[519] Torrance and Perron both proposed that the increasing complexity of the hospital and the shift from a small enterprise to an almost industrialized institution lead to unionization.[520] The EGH was living through these changes, and one of the universal symbols of industrialization was introduced in the hospital in 1941. In January of that year, the Sisters decided to install a time clock because salary inspectors had found that the EGH did not have good methods to monitor employees.[521] It may be that the increasing size of the institution reduced the chance for personal contacts between employees and employers, thus resulting in the need for a more structured automated and ultimately impersonal way to seek improvement in working conditions. Understandably, the movement towards unionization emerged after the end of World War II. Union leaders probably felt that *stirring the pot* while soldiers were dying overseas would have outraged the Canadian public. However, the stage had been set and the union movement swept the country.

---

[514] ASGME, EHH, Doc. 102A, Letter of L.D. Giroux to Sr Gosselin, Edmonton, 3 February 1920.

[515] ASGME, EHH, Doc. 102A, Letter of J. Antrobus Secretary Treasurer of the Canadian Brotherhood of Stationary Engineers and Firemen to the General Hospital, Edmonton, 24 April 1920.

[516] ASGME, EHH, Doc. 102A. Ibid., 7 May 1920.

[517] ASGME, EHH, Doc. 102A, Memorandum of agreement.

---

[518] Kerr suggested that the passage of this law, "... was probably instrumental in the 1944 CNA decision to support collective bargaining among its member associations." Janet Ross Kerr, "Emergence of nursing unions as a social force in Canada," in ***Canadian nursing issues and perspectives***, 2d ed., ed. Janet Ross Kerr and Jannetta MacPhail, (Toronto: Mosby Year Book, 1992), 210.; it is suggested here that other groups of hospital workers were also influenced by the act.

[519] George M. Torrance, "Hospitals as health factories", in ***Health and Canadian society. Sociological perspectives***, ed. D. Coburn, C, D'Arcy, G. Torrance and P. New, (Markham, Ontario: Fitzhenry and Whiteside, 1987), 481.

[520] Ibid., 481-483; Normand Perron, ***Un siècle de vie hospitalière au Québec, les Augustines de l'Hôtel-Dieu de Chicoutimi, 1884-1984***, (Québec: Presses de l'Université du Québec, 1984), 248.

[521] ASGME, EGH, Chroniques, January 1941.

The Roman Catholic Church responded directly to the forces which were creating a new social environment by reaffirming its position on labour relations. In 1891, Leon XIII, often referred to as the "workers' pope", had published the encyclical ***Rerum Novarum***. Appalled at the conditions which prevailed in factories, Leon XIII pleaded for adequate salaries, work conditions and social justice in general.[522] In 1931, Pius XI gave support to the position of Leon XIII and added his own beliefs in ***Quadragesimo Anno***.[523] In Quebec, where the Catholic Church was omnipresent, the publication of this document contributed materially to the establishment of Catholic unions.[524] In general, Quebec priests believed that facilitating the establishment of Catholic unions would curtail the growth of communism. After World War II, against the will of much of the clergy, a number of non-confessional unions were formed in that province. However, some vocal members of the church establishment openly favoured the new trend.[525]

Roman Catholic hospitals were directly affected by the official views of the Church. Through Canon Law, Rome stipulated the rules of conduct of religious orders towards their employees. These rules dictated that employees were to be given just and reasonable salaries, that religious practice had to be facilitated, that employees were never to be diverted from family responsibilities, and that work assignments had to be compatible with the individual's age and gender.[526] Although these rules were impressive on paper and were clearly in tune with social customs, it is evident from the standpoint of the 1990's that they were discriminatory to women. By stating that employees were not to be diverted from their family responsibilities, the implicit conclusion was that married women were not to work outside the home. However, the Catholic Church was not the only church opposed to women's work; most if not all Christian denominations were unanimous on that matter. Yelle's interpretation of this rule further suggests that it was specifically included to regulate women's life. He stated that a wife should be in the home and that the best way to facilitate this was to ensure that husbands were paid sufficiently well to be able to support their families. He also believed that good salaries could lead to a more stable workforce.[527] A direct consequence of the above was that single women could be given lower wages since they did not have to support a family. Interestingly, Yelle specified that the attribution of lower wages should concern only women who did not have a special training and he expressed concern for the nurses' situation. He wrote: "Actuellement elles ne peuvent guère compter que sur l'hôpital ou les clients de l'hôpital pour vivre. Je crains qu'au nombre de garde-malades qui sont graduées chaque année, et au taux des salaires qu'elles reçoivent dans nos maisons, elles ne forment avant longtemps une classe de mécontentes qui risquent, pour plusieurs, de mal tourner. Il y a là un problème qu'il serait urgent d'étudier de près, et à la solution duquel il importe de travailler."[528] Although Yelle did not propose a solution it is interesting that he recognized that the education of nurses should give them a special status among women employees. It would have been interesting to be able to determine if Yelle had written this document prior to or after the publication of the Weir Report.[529]

---

[522] Yves Tessier, ***A l'ombre du Vatican. L'histoire des relations entre l'Eglise Canadienne et le Vatican de l'époque amérindienne à nos jours***, (Québec: Les Editions Tessier, 1962), 64; ASGME, EHH, Doc. 194, Emile Yelle, Coadjutor of St. Boniface, Doctrine de l'Eglise sur le salaire des ouvriers, (n.p., n.d. However, judging by the content it seems that the document was probably published in the 1930's and its format and typeset suggest that it was originally published in a periodical), 2.

[523] Tessier, ***A l'ombre du Vatican***, 82.

[524] At the end of the 1930's half of the unionized employees of the province belonged to a Catholic union. Jean Hamelin, ***Histoire du Québec***, (Montréal: Editions France-Amérique, 1977), 476.

[525] Father Lévesque, the founder of the *Faculté des Sciences Sociales* of Laval University and Mgr Charbonneau the archbishop of Montreal fought against the position taken by the Duplessis's government during labour unrest and supported the creation of non-confessional unions. Of particular interest in this study, Mgr Charbonneau supported the nurses of Quebec who wanted to create a collective bargaining unit in 1946. Tessier, ***A l'ombre du Vatican***, 86.

---

[526] Yelle, Canon Rule 1524, "Doctrine", 1.

[527] Ibid., 5.

[528] Quote translation: Currently, nurses can hardly count on hospitals or hospitals' clients to earn their living. I believe that considering the number of nurses who graduate every year and the salary they receive in our hospitals that soon they will make a class of discontent individuals, many of whom may end "turning bad". It is urgent to study the problem of nurses and propose solutions. Ibid., 6.

Employment benefits of the 1940's and the first two unions

Four general benefits were gained by all employees in 1947 and 1948. In 1947, a group life insurance plan (voluntary) and an pension plan were established. The premiums for both plans were shared between the employer and the employee. In 1948, Blue Cross coverage was offered. The hospital contributed 50% of the premiums for employees who had worked for the institution for more than five years. It provided 35% of the premium for those who had been staff members between one and five years, and 25% for new employees. The same year a workmen's compensation scheme was adopted.[530] Finally, a hospital health office offering services to employees was established in 1947.[531] The implementation of these plans reflected societal changes in which it was perceived that employers and governments should assist individuals by actively supporting measures which could provide a safety net in case of injury, disease and other debilitating problems. The economic crisis of the 1930's was a painful memory and since the end of the war the nation had the time and financial resources to implement changes.

That a union movement had been developing during the war years is best shown by the fact that as early as 1946, the topic was frequently discussed at the meetings of the AHA and the CHAA.[532] Soon after the end of World War II, two unions were established at the EGH. Considering the contract signed by an engineer in 1921, it is not surprising that the hospital engineers (five by then) were the first to gain collective bargaining rights. The second group to gain similar rights was composed of support employees. There is no evidence that nurses, who were the only other large group of employees, sought to obtain collective bargaining privileges. Nurses probably considered the issue in a different manner. Unions were associated with the trade union movement which possibly had little appeal to a group of women attempting to gain full professional status.

---

[529] The Weir Report was published in 1932. This document incorporated a comprehensive study of nursing in Canada jointly sponsored by the Canadian Nurses Association and the Canadian Medical Association.

[530] ASGME, EGH, Chroniques, 1947 and 1948.

[531] Ibid., 1947.

[532] Juzwishin, "A history of the Alberta Hospital Association", 107; Castonguay, ***A mission of caring***, 24-25.

In October 1947, the EGH chronicles noted that union leaders "had insidiously" managed to convince Saskatchewan hospital workers to become unionized. In order to prevent a similar situation from occurring at the EGH, the Grey Nuns decided to organize a general meeting of all employees. The first meeting took place on October 9 and on December 12, employees elected colleagues who would officially represent them. Significantly, the superior of the EGH was named honourary president, while the president and vice-president were French Canadian engineers and the secretary was a female office worker. At the same meeting it was also decided that employees would pay a union fee of twenty-five cents a month.[533]

The sisters continued to be proactive, and in June 1948 they adopted a personnel policies document.[534] It is very likely that they used AHA policy documents as guiding tools, since the AHA was very involved in hospital labour relations. The three page document was much more detailed than the engineer's contract of 1921. It included the idea that work schedules were the prerogative of the employer and that after a year of employment, staff members would be entitled to two weeks' annual vacation. Fourteen statutory holidays were also granted according to a formula which took into account the occupation of the worker. Interestingly, four of these holidays were Catholic in nature; at the time these were civic holidays in Quebec: Epiphany (January 6) Ascension (May

---

[533] ASGME, EGH, Chroniques, October 1947 to December 1947.

[534] ASGME, EGH, Employés: Hôpital Edmonton, 1947 to 1950. Edmonton General Hospital personnel policies, June 1948.

6), All Saints' Day (November 1) and Immaculate Conception (December 8).[535] It was also specified that anyone absent for illness had upon return to work to report to the health nurse and that sick leaves were granted according to seniority and performance. Finally, it was stipulated that employees were covered by the workmen's compensation and that after twelve months of service they were eligible for group insurance and pension plans. Interestingly, it seems that these personnel policies were not applicable for nurses.[536] This shows that the employer perceived nurses to be a different group of workers.

The creation of a pseudo-union and the establishment of clear personnel policies reflected the wish of the sisters to curtail outside influence. It is likely that they believed that by being proactive, they could shape the course of events and curtail conflicts. However, the stand taken by the sisters would not prevent formal unionization of groups of staff.

Engineers

In November 1948, the Superior was visited by two employees of the provincial department of industries and labour. They informed her that the five engineers had applied to become members of the provincial union of engineers. The Superior took the matter seriously since right after the meeting she asked the University of Alberta Hospitals to forward a copy of their engineers contract. However, she could not stop the inevitable and by the end of the month, the engineers had joined the provincial union.[537]

In January 1949, a representative of the Board of Industrial Relations informed the Superior that the engineers were requesting a 40 hour work week (48 hours was the norm at the time) and full salary when absent for illness. This time, the Superior considered the matter sufficiently serious to call for a meeting of the Advisory Board.[538] Based on the requests made by the engineers in 1950 it is apparent that they did not obtain a 40 hour week in 1949.[539] The outcome in respect of sick days could not be determined.

---

[535] The other ten holidays were regular civic holidays in Alberta such as Christmas, New Year, Victoria Day and Dominion Day.

[536] The following employees were listed in the document: cafeteria workers, carpenters, clerks, department heads, dieticians and their helpers, elevators and switchboard operators, engineers and their helpers, ground's men, janitors, laboratory technicians, main kitchen and diet kitchen staff, nurses' aides, painters, pharmacists and their helpers, radiology technicians, seamstress, students and helpers and ward aides.

[537] ASGME, EGH, Chroniques, November 1948.

Concerns of the Catholic clergy

The local clergy was obviously concerned about the new trends in labour relations. In late January, the *Social Justice Clergy Club of Edmonton* met at St. Joachim's church and proposed that since hospital employees wished to have a formal means to solve grievances, that Catholic hospitals' authorities should join in their efforts and initiate the process towards the creation of one Catholic hospital workers' union. Records of the resolution adopted at this meeting revealed that the clergy's position was based on the "Great Papal Encyclicals" (Leon XIII and Pius XI).[540] The Grey Nuns had been invited to the meeting and the Superior stated that the creation of a single union for all hospitals would be impractical. Her concern was obviously well received since it was proposed in the resolution which was adopted namely that the creation of unions could be addressed on an individual basis.[541]

Support staff union, local 123

In February of that year the Grey Nuns requested the assistance of Mr. Emmet Hall, a lawyer from Saskatoon. Consulting him about unionization was a judicious and logical decision since he had assisted the Grey Nuns of Saskatoon in similar matters which had arisen earlier in that province.[542] Mr Hall agreed to come and while on site he reviewed the personnel policies, met with the engineers and representatives of the Department of Labour and invited all support employees to a general meeting. At this meeting he addressed the question of unions and stated that the hospital authorities agreed with the concept of creating a formal union and that employees were free to organize such an association if they wished to. It was noted in the chronicles that Mr. Hall had been very impressed by all what was already in place for the EGH employees and that he felt that it would be preferable to create a union on site before outsiders took advantage of the *momentum*.[543]

---

[538] Ibid., January 1949.

[539] Ibid., April 1950. The engineers were then negotiating for a 44 hour week.

[540] ASGME, EHH, Doc. 198. January 1949. The date of the foundation of this club could not be determined.

[541] Ibid.; It would have been interesting to be able to determine if the Sisters of Misericordia were present at the meeting and if they were, their position on the matter in question.

Two weeks after Hall's visit a general meeting was called. After a few hours of discussion a union was created, and by the end of the meeting 80 employees had become members of the new organization.[544] The exact attendance at the meeting could not be determined. However, the way the chronicles were written suggest that some employees did not vote in favour of creating that union.[545] Some hesitation would have been normal. However, it is likely that few were radically opposed. At the time, the hospital had 165 employees who could have joined that union.[546] Based on the vote in favour it is known that almost half of the workforce voted in favour of creating a union. Since it is unlikely that more than 75% of the employees would have present at the meeting it seems that the wish to unionize would have been fairly strong since 80 individuals supported the move.

---

[542] The expertise of Mr. Emmet Hall in the health care field became well known in the 1960's when he was selected as the Chairman of the Royal Commission on Health Services. The Grey Nuns considered him as a strong ally.

[543] ASGME, EGH, Chroniques, 4 February 1949.

[544] Ibid., 21 February 1949.

[545] It was noted in the chronicles that 80 employees decided to join. It seems logical that if the decision would had been unanimous, it would had been reflected by a specific statement of the author.

[546] ASGME, EGH, Annual report, 1949.

On March 11, four officers were selected, three of whom were French Canadian men and one a women of Ukrainian background who was assigned the position of secretary. The choice of French Canadian leaders may have been seen as advantageous since most sisters were from the same cultural group. Considering that there were 44 men and 121 women in the support staff, it is apparent that women were under-represented in the union leadership positions. Importantly, the engineers decided to maintain their own collective bargaining unit.[547] By July 1949, a new contract had been signed and the support staff union had become "Local 123" of the Building Services Employees International Union.[548]

It is important to recall that in January 1949, the clergy had favoured the creation of a Catholic union. Obviously this wish had not materialized. However, the chronicles revealed that in February, the Superior had consulted Bishop MacDonald and that he had given support to an affiliation with an international union.[549] The reasons behind his position could not be determined. He may well have been influenced by provincial tendencies. Indeed Catholic unions were rare in Alberta and following the Quebec model was probably impossible in a milieu separated geographically and culturally from that province.[550]

Negotiations of the engineers' union and of Local 123

In April 1950, the engineers requested a 44 hour work week and the hospital administration agreed to have a three month trial period.[551] There is a comment in the chronicles that this schedule was far from practical "but that soon they would have to face the union leaders whose intentions were to keep this number of hours of work and to request better salaries."[552] The collective bargaining process started in May and negotiations were difficult enough to require conciliation. It took a year to reach an agreement. A settlement concerning salaries could not be found. However, in order to maintain the 48 hour work week, the hospital authorities compromised to increase the number of weeks of vacations from two to four.[553] The request for a 44 hour week was brought again in July 1952. It took one week to reach an agreement and the number of hours of work again remained unchanged; instead the employees received a salary increase of $5.00 a month.[554]

---

[547] ASGME, EGH, Chroniques, 11 March 1949.

[548] Ibid., July 1949; In the rest of this chapter "Local 123" is used when writing about this union.

[549] Ibid., February 1949.

[550] In the late 1940's, most support employees of Quebec's hospitals belonged to the Confederation of Catholic Workers of Canada. Perron, ***Un siècle de vie***, 282.

[551] In 1948, the Alberta Federation of Labour informed the CHAA that it favoured the 44 hour work week. Castonguay, ***A mission of caring***, 28.

In May 1953, Local 123 succeeded in obtaining a 44 hour week.[555] By May 1956, both unions had obtained the 40 hour week.[556] Therefore, it took the unions seven years to reach this goal. The 40 hour week appeared not to please the administration, but it accepted it and necessary compromises were made. Schedules were drawn by department heads who took into account the needs associated with the services they offered. In offices, "two day" weekends were instituted while in some departments the additional day off was split into two half days. In one service the same goal was reached by decreasing the work day by 45 minutes. The words used in the chronicles best describe the situation: "We have to give the same service seven days a week and as much as possible without increasing the number of employees. Much time is lost at coffee breaks; exaggeration will have to be stopped."[557] It appears that the hospital was fairly successful in avoiding a great increase in the number of employees.[558] The number of hours of work must have been the bone of contention of previous negotiations, since in 1958 it took one hour to negotiate new contracts.[559]

---

[552] ASGME, EGH, Chroniques, April 1950.

[553] Ibid., May 1951.

[554] Ibid., July 1952.

[555] Ibid., May 1953.

[556] Ibid., May 1956.

[557] Ibid.

The data did not reveal the salary levels that were negotiated in the 1940's and the 1950's. However, in 1948, the Alberta Federation of Labour recommended a minimum wage of $0.75 an hour for men and $0.40 an hour for women.[560] Based on the EGH contracts of the 1960's, it is clear that women were paid less than men. The low representation of women in the collective bargaining units as well as the patriarchal biases of the time certainly contributed to the difference in salary. Needless to say the question of maternity leave was never addressed, hardly astonishing since at the time marriage meant the end of a woman's presence in the workforce. It is also common knowledge that prior to the 1967 Royal Commission on the Status of Women, this type of issue was rarely raised.

Interestingly, the chronicles of the 1960's did not include much data about collective bargaining. The novelty had disappeared and it is probable that mentioning the topic in the chronicles did not seem relevant. However, an interesting incident was reported in November 1963. The hospital lawyer had won a court case on behalf of the hospital administration which had been brought by Local 123. The union had claimed that the hiring of a private housekeeping company (in October) had constituted a breach of contract.[561] This event shows that the hospital administration must have considered that money could be saved by contracting with a private cleaning firm. Since costs were escalating rapidly, it must have been believed that measures such as this one needed to be taken in order to curtail the upward spending tendency.

---

[558] Only 25 people were added between 1955 and 1956. ASGME, EGH, Annual Reports, 1955 and 1956.

[559] ASGME, EGH, Chroniques, January 1958.

[560] Castonguay, ***A mission of caring***, 28.

[561] ASGME, EGH, Chroniques, 10 November 1963.

Collective bargaining in nursing

A remarkable feature of the 1960's in collective bargaining issues was the awakening of nurses. In Canada, the post-war years were characterized by an increase in the number of hospital beds and by the growth of the public sector. During these years nurses and women began to be more assertive in the field of labour relations. In Alberta, in 1965, the AARN obtained the right to act as bargaining agent for nurses.[562] However, the AARN had been active prior that time and as early as 1945, it had established a joint committee with the AHA. The mandate of this committee was to recommend personnel policies including salary, vacation and holiday guidelines which hospitals used at their own discretion.[563] Meetings were held sporadically and the negotiation of salary scales did not seem to create much difficulties. Nurses were probably not asking for much at the time, otherwise conflicts would have arisen as they did in later years. In 1942, the AARN proposed an official salary scale but no details could be found and it was impossible to determine if the EGH adopted that scale.[564]

The first documents which were found in respect to nurses salaries and working conditions were written in 1956 and 1957. The working conditions of nurses were addressed in a 1956 document.[565] It was stipulated that a 40 hour week would be adopted in September 1956 and that split shifts would be assigned only on a temporary basis. Nurses were expected to work four to six weeks on days followed by two weeks of evening and two weeks of night duty. Interestingly, a shift differential of $8.00 a month was provided for those who agreed to work the evening shift for three consecutive months. Under the same conditions, a nurse could receive a differential of $5.00 for selecting the night shift. The length of annual vacations varied according to the level of responsibilities. All general duty nurses enjoyed 21 days of vacation a year. However, head nurses and supervisors had 28 days after having been in that position for a year, and supervisor could obtain two more days after five years of service. Finally, sick leave days were secured at the rate of one and a half day a month cumulative to a maximum of 60 days. Other benefits were identical to those found in the contracts of other employees. The exact salary of nurses in the 1950's could not be found. However, the accountant's correspondence revealed that as of September 1957 nurses would be granted a salary increase of $20.00 a month.[566]

---

[562] Kerr, "Emergence of nursing unions", 210-211.

[563] In the late 1950's, similar committees were established between the AHA and other hospital technicians or professionals such as dieticians and physiotherapists. No contracts related to these occupations were found in the ASGME collection. Juzwishin, "A history of the Alberta Hospital Association", 126-127, and 208.

[564] Myskiw, "The influence of the Alberta Association", 144.

[565] ASGME, EGH, Graduates in service: Edmonton, Statuts des infirmières graduées en service à l'Hôpital Général, 1956.; The AARN and AHA had designed a personnel policy for nurses in 1947. However, it was not possible to establish if this policy was used at the EGH. Myskiw, "The influence of the Alberta Association", 173.

Nurses became clearly more militant after 1965 and the negotiations of 1968 were more strident. It seems that the sisters foresaw difficulties. On September 24, 1968 board members (all sisters) raised concern about the role of the AHA in nursing and technicians collective bargaining issues. They believed that the AHA had been supportive of the hospital's needs, but they feared that too much delegation would result into a weakening of the hospital's decision making power. The concern was not exclusively budget-related. "Salaries represent about 65% of the hospital budget, as such, the Directors are deeply concerned not only with these expenditures, but also are concerned with retaining something of the intimate relationships which exist between the hospital and its employees in the field of personnel and human relations." It was decided that collaborating with the AHA was essential but that efforts would be made to remain autonomous.[567]

The round of negotiations between the AARN and AHA was difficult and in

---

[566] ASGME, EGH, By-laws and policies, 1940-1960. Sister Plotkins, hospital accountant to Mr. J.D. Campbell, Director of the Hospital Division of the Alberta Government, 10 June 1957.

[567] ASGME, EGH, Minutes of the Board of Directors of the Edmonton General Hospital (MBD), 24 September 1968.

February 1968 they had reached the stage of requiring the use of a conciliation board. Initially, the AARN had requested a one year contract including a 25% increase in salary while the AHA was only willing to offer 5%. After meeting with a conciliation officer the AHA proposed a two year contract in which a raise of 8.6% was to be given the first year followed by a 6.8% increase the second year. The AARN counter-offer consisted of a two year agreement calling for an increase of 11% followed by a 9% raise. The conciliation officer suggested a one year agreement in which starting salaries were initially to be increased from $405.00 to $430.00 a month and then raised to $455 for the second six months. His proposal represented around a 12% increase.[568] This proposal was rejected by both parties. After months of negotiations an agreement was reached in April 1969. Starting salaries were initially raised to $440.00 a month while they reached $456.00 during the last eight months of that contract. It was also agreed that in May 1970 a sixth level would be added to the salary scale.[569] Therefore, in final count it meant that by the end of the new contract a 14.8% raise was in place. Thus it seems that the AARN received 9.8% less than initially requested and that the AHA had to give 9.8% more than it had planned.

The impact of this new contract on the salary of *out of scope* nurses could not be determined. However, information about their 1967 salary scale was provided in another document.[570] It is worth mentioning that a note included that the EGH scale discussed in this document had been proposed by the CNA to the AHA who had endorsed it for 1967. Minimum monthly salaries were: $415.00 for a unit supervisor, $480.00 for a supervisor and $500.00 for a director. In light of the increase provided to general duty nurses in 1969, it is suggested that the salaries of these individuals would have had to increase proportionately, if nurses in supervisory positions were to be paid at least as much as general duty nurses. Of interest, these individuals received small monetary reward for further education. At the fifth level, a unit supervisor who had a diploma education made $555.00 a month, if she had a bachelor degree she made $615 a month, and if she was masters prepared her salary reached $630.00 a month. Assistant directors of nursing with the same levels of education made $600.00, $660.00 and $675.00 respectively.

---

[568] He had also suggested that the salary scale should be increased from five to six levels.

[569] ASGME, EGH, MBD, April 1969; Union and arbitration award: Summary of conciliation board award between the AHA and the AARN, 1969.

[570] ASGME, EGH, Edmonton Hospital Agreements, Letter of Sr Laporte, Superior Provincial to Sister Chaloux, Administrator of the EGH, St. Albert, 5 January 1967.

The double standard

The employees of Local 123 received an 11% raise in 1969.[571] Thus, in 1969, the beginning salary of a carpenter was at least $455.00 a month.[572] In contrast, the starting salary of a nurse was $440.00 a month. This example gives evidence that nurses were paid less than at least one group of male employees who did not even had the same level of education. This type of inequity was common and far from new. It has already been stated that in 1921, the boiler engineer (who was not an engineer in the current use of the term) made $140.00 a month. For the same year the AARN estimated that the average salary of nurses was of $110.00 a month.[573] In 1968, an assistant engineer made $575.00 a month.[574] Since an engineer was certainly paid more than an assistant, it shows that the gap between the salary of nurses and this category of worker had in fact increased. In light of this, the gains made nurses in 1969 should not be taken at face value. That the AHA had initially offered a 5% increase, further demonstrates the bias that existed against nurses.

---

[571] ASGME, EGH, MBD, April 1969.

[572] In 1965, the beginning salary of a carpenter was $410.00 a month, including the 11% increase of 1969 this salary became $455.00. This of course assumes that no other raises were given between 1965 and 1969. ASGME, Edmonton Hospital Agreements, Summary of the collective agreement for Local 123 for the period of April 1965 to December 1967.

[573] Myskiw, "The influence of the Alberta Association", 173.

[574] ASGME, EGH, Board of directors papers, salary review of 1969.

The discriminatory treatment towards women was also strikingly apparent when comparing the salaries of women who belonged to Local 123 with the salaries of the men in the same union. In 1965, for example, the maximum salary of seamstresses ($215.00) and of clerk typists ($262) were well below the minimum wages of carpenters ($410) and inferior to the maximum salaries of men with even less education and fewer skills such as porters ($275) and janitors ($295.00).[575]

It is clear that between the late 1940's and 1970, that working conditions improved. The work week was reduced from 48 to 40 hours and wages were increased. However, there was constantly discrimination against women. The post-war years brought union militancy in the hospital but there is no evidence that it contributed to reduce the gap between women's and men's salaries. It has already been stated that women were poorly represented in the hierarchy of Local 123. Based on the difficulties and the outcome of the 1967 to 1969 nursing negotiations it may be suggested that even a better representation of women in Local 123 may not have made a significant difference; the gender bias was simply too pervasive in Canadian society. It is clear that in the 1990's women continue to be paid significantly less then men even when they have equivalent levels of preparation.

This analysis of collective bargaining at the EGH also shows that negotiations could be arduous and that conciliation had to be called upon at least twice. The hospital administration demonstrated the will to follow the Roman Catholic principles of social justice. However, it is clear that translating these principles into action was a difficult task, and that the scales of justice were set in favour of men. Nevertheless, the data presented in the next section shows that generally employees enjoyed positive relationships with their employer. In addition, there was not a single strike and there is no evidence of serious confrontations that could have affected patient care. As reflected by statements found in the papers of the Board of Directors the sisters saw value in having a family-like atmosphere in the institution.

---

[575] ASGME, Edmonton Hospital Agreements, Summary of the collective agreement of Local 123 for the period of April 1965 to December 1967.

The work family

Prior to the 1920's the chroniclers were rather silent about employee/employer relationships.[576] It is true, that during those years the workforce was very small (less than 20). The majority of these employees were unskilled individuals who for the most resided at the hospital. At the time, in North America the practice of living at the hospital was still fairly common. At the EGH changes in relation to staff housing started to occur in 1928. The chronicles revealed that in May of that year the male staff moved to a rented house and that some female workers we relocated to the old male quarters.

Social activities for employees must have existed from the outset. However, the first specific event that was recorded occurred in 1923. In November of that year the employees showed their acting talents by staging a play.[577] Interestingly, organized events seemed to begin to be common in the late 1940's, at the same time as collective bargaining units were being established. The employees desire to create such units can be considered an important indicator of the transformation that had taken place in the hospital. The evolution of the institution can easily be compared to the evolution of a family. Using this model, an explanation of the timing of the development of formal social events can be suggested. Initially, the hospital was like a family home. However, by the late 1940's this homelike atmosphere was becoming less obvious. Initially, the employees all lived under the hospital roof. This was no longer the case in the late 1940's. In a real family, when children leave home and start raising their own families, events such as Christmas and Thanksgiving often become the only occasions when all siblings are reunited under the parental roof. Although the employees were still working at the EGH it was no longer their home. In order to socialize they had to organize special events. By claiming the right to negotiate their working conditions, the employees were also affirming their new independence. In itself, the movement towards unionization created structures that could be called upon for other use than collective bargaining. The employees had a new tool that could facilitate the organization of activities.

---

[576] Much more was written about the relationship with nursing students.

[577] ASGME, EGH, Chroniques, November 1923.

Employees' Newsletter

In 1947, the employees took the initiative to start publishing a hospital newsletter. In the first issue of *Team Work* the instigators revealed the goals of the publication. They wanted to encourage positive relationships between professional and non-professional staff, foster team spirit among employees, and give to the public a better understanding of the "modern hospital".[578] The three goals of the publication are revealing. The first goal suggests that the movement towards collective bargaining was exacerbating the differences which existed between professional and non-professional staff members. It may indicate that the new militancy of the support staff made them want to clearly demonstrate that the services they provided were essential to the day-to-day functioning of the organization. The third goal was also linked to demonstrating their contribution. It may be suggested that they wished to show to the public that professional services could not be provided without the support they offered. The second goal and the name of the publication provide further evidence that they considered themselves as an integral part of the hospital. Finally, by specifically using the term "modern hospital" they were acknowledging that the hospital world had changed and implicitly that it would continue to change. The impact of *Team Work* could not be determined. However, it may be proposed that it was seen as a valuable tool since it continued to be published at least until 1951.[579]

The Christmas season

Christmas celebrations

The chronicles revealed that prior to the 1940's, the employees often accompanied the sisters to midnight mass and that sometimes little presents were exchanged. A new tradition began in 1948, when the employees began organizing an official Christmas party, to which the sisters were always invited.[580] Starting in 1961, the sisters began to organize Christmas potluck luncheons on each nursing unit.[581] Although, organized parties became important, the religious essence of Christmas was preserved throughout the period under investigation and staff members usually attended mass at the hospital chapel. It is worth mentioning that in 1951 a young Italian cook decided to organize a special Christmas mass for the Italian employees. A Salesian brother who could speak Italian conducted the ceremony and according to the chronicles the chapel was full and all were very happy. [582]

---

[578] ASGME, EGH, Chroniques, November 1947. Unfortunately it was impossible to trace any issues of *Team Work*.

[579] The longevity of the publication could not be determined. However, the publication was mentioned in the chronicles in June 1951.

Gifts from physicians

The physicians often gave Christmas presents to the employees, the students, and the sisters. It appears that this practice became more formalized in the 1950's when a Christmas fund was created. As physicians were regularly spending close to $1000.00 in various presents, it seems logical that they would have wanted to plan ahead of time. It appears that the practice of giving individualized presents stopped in the 1960's. By then the hospital workforce was so big that it would have been considered unrealistic to buy a gift for everyone. The minutes of the medical staff meetings provided detailed list of the Christmas presents that were given between 1950 and 1968.

Chocolate and nuts were commonly distributed to all departments. In 1950 the recorder of the minutes of the medical staff meetings accurately described the EGH as the "Palace of sweets". That Christmas, 200 pounds of nuts and chocolate and been distributed. Employees were often given personal items such as neckties and handkerchiefs. The physicians were particularly generous towards nursing and medical students. Every year both groups of students received a subscription to a professional journal. Invariably *The Canadian Nurse* was selected for nursing students. A large gift was also always given to each group of students. For example student nurses received a number of sewing machines and hair dryers, a ping pong table, a television and a washing machine, while interns received electric razors, a pool table, a television and numerous books. Interestingly the other students of the hospital were usually given gifts certificates. It thus seem that more time was spent thinking about what would please nursing and medical students. Registered nurses were also among the beneficiaries of special gifts. Over a number of years they received items to furnish their rest area. For example they received new drapes, chairs, tables and lamps. Finally, the sisters usually received money to be used at their own discretion. Although the physicians of the era at times displayed paternalistic behaviours towards students, their generosity at Christmas time must be seen as a positive display of their good will towards students. In general, the practice of giving gifts also reflected the physician's position in the hospital hierarchy.

---

[580] ASGME, EGH, Chroniques, December 1948 onward.

[581] Ibid., December 1961 onward.

[582] Ibid., 23 December 1951.

Long service awards

Beginning in 1947, the sisters organized a yearly banquet which purpose was to recognize the employees who had served the hospital for more than five years.[583] It is interesting that this practice began at same time that employees were seeking collective bargaining rights. Employees usually received a "medal" of service. Five years of service was recognized by a silver medal, and ten to twenty-five by different gold medals. Significant numbers of employees were rewarded in this manner. In the 1960's at least 145 employees were rewarded for having work between 10 and 30 years. This longevity can serve as an indicator of the work climate that existed at the EGH. The post-war years were a boom period. Thus, it may be suggested that if the employees had not been satisfied many would have been able to find employment elsewhere. It is also meaningful that at the 1962 banquet, the employees showed their appreciation to the Superior who was being transferred to another hospital. They gave her a suitcase and the union leader also donated a cheque on behalf of the union members.[584]

---

[583] Ibid., 1947 onward.

Other social activities with the sisters

The data revealed that sisters and employees did other activities together. However, when the sisters shared social activities with employees it was usually with nurses or nursing students. This is not surprising since a large number of sisters were nurses and that sharing activities with other women was more acceptable for members of a female religious order. Activities varied from movie sessions, to recreational evenings including display of music and acting talents.[585]

The engineers seemed to enjoy very positive relationships with the sisters. In particular, a number of picnics were reported in the 1950's and 1960's.[586] On at least two occasions, the chief engineer invited the sisters to his summer cottage. Engineers provided car rides and supper consisted of barbecued fish.[587] Incidently, in 1955, the engineers gave the sisters a barbecue stove that they had specifically built for them.[588] These events are important since they show that even if negotiations of contract were not always easy, they did not mean the end of positive relationships.

In conclusion, the EGH workforce grew with the institution and it also changed as specialization increased. Importantly, the proportion of lay staff always increased. However, because of the leadership roles they occupied, the sisters continued to be a dominant force in shaping the institution. Shortages of staff were recurrent and predominantly linked to national and world events and to cultural traits of the time. The shortages were particularly acute during and after World War II. Shortages of nurses were specifically linked to the place of women in society and to the use nursing students as employees. Significant changes began to take place in the late 1940's. In particular, unions were created and new technical fields became more specialized. The views of the hospital administrators in respect of collective bargaining were influenced by the official position of the Roman Catholic Church. The changes in the administrative structure, which took place in the 1960's made the hospital more complex and probably more impersonal. However, as shown by the results presented in the last section of this chapter, the sisters tried to foster positive relationships with employees, and the number of individuals who received long service awards indicates that the hospital was able to retain its staff.

---

[584] Ibid., 1962. The chronicles did not reveal which union gave this cheque.

[585] This topic is further addressed in the chapter on the school of nursing.

[586] ASGME, EGH, Chroniques, 1950 to 1970.

[587] Ibid., July 1955 and August 1960.

[588] Ibid., 1955.

CHAPTER 13

THE EGH SCHOOL OF NURSING: 1908-1973

Many reasons make essential the inclusion of a chapter on the school of nursing. A widespread problem with most hospital histories is that little consideration is given to the nursing component of the hospital. This is alarming considering that nursing is clearly the largest, and certainly a vital service of the hospital. A premise of this study is that nursing must be addressed and since for most of this century, nursing students played a vital role in nursing care delivery it is logical to examine the data pertaining to them. The central mission of the hospital has always been to provide patient care even if the type of care has varied over time. However, hospitals have also played other roles in society.[589] Among these, an important one has been to contribute to the education of health professionals. This role clearly emerged at the end of the last century and it thus appears that some attention must be given to this aspect when studying the history of the modern hospital. Even though for most of the period under investigation the involvement of hospitals in the field of education was primarily based on self-serving motives, the fact remains that nurses and other health care personnel were prepared at these institutions. The extent to which the hospitals participated in, and controlled the education of these future workers varied over time and among professions. For example, for most of the twentieth century, medical students have been guests in the hospital and their education has been the responsibility of university based medical schools. In contrast, the majority of nursing students have been pupils of the hospital via its school of nursing. In that model, the hospital was in full control of nursing education and this was not without consequences. A symbiotic relationship between the school of the nursing and the nursing service of the hospital existed to such degree that it often blurred and diminished the educational mission of the nursing school.

The data presented in this chapter shows that this type of relationship existed at the EGH. Illustrative of this relationship is that students were often referred to as "the nurses" as opposed to "the students" and that much of the data pertaining to nursing in general was found in the archival material related to the school. Importantly, it was in this material that the views of the Grey Nuns on nursing were the most explicitly stated. Thus examining the school data was essential in order to glean better understanding of the nursing situation at the EGH. From a methods point of view, this finding is important because it is likely that in other situations examining the school of nursing records of hospitals could lead to a better understanding of the history of nursing at these institutions. Considering the school of nursing was also important because some of the data pertaining to graduates provided indicators of the social context of the hospital in the Franco-Albertan community, the city and the province. This chapter is divided into four sections: the origin of school graduates, the growth of the school, student attrition, and the education and life of nursing students. Most results are presented chronologically and grouped into four eras; 1911 to 1918, 1919 to 1938, 1939 to 1958, and 1959 to 1973.

---

[589] Shelter for the poor, prison for women, research and education are some of the roles that have been played by the hospital.

The origins of graduates of the school

The data examined in this section was found in the school of nursing register of graduates.[590] This document provided class lists of all graduates per year from 1911 (first graduating class) until 1973 (last graduating class). Towns of origins were also listed for most of the students who graduated between 1916 and 1971. Unfortunately, the records were not explicit enough to determine if the listed site was the place of birth or the place of residence prior to enrolment. It seems that prior to the mid 1930's the listed location must have been the place of birth since a relatively large number of American and Eastern Canadian locations (almost all those found in the total sample) were listed. Most of these graduates must have emigrated to Alberta while they were children since it is unlikely that if they had been residents of the listed locations they would have come to Edmonton to study nursing because the identified areas also had schools of nursing. The fact that it is impossible to determine where these students lived immediately prior to enrolment is a limitation.

---

[590] ASGME, EGH School of Nursing files, Ecole des infirmières - registre des infirmières graduées, 1911-1973.

However, the situation is somewhat different after the mid 1930's, since in some cases the statement "no address recorded" was found in the data. This statement likely indicates that the location provided during these years was the address prior to enrolment or the parents' current address. It must also be recalled that a document about construction planning in the late 1930's revealed that following the opening of the large tuberculosis section few students from Edmonton applied to study at the EGH. Data found in the graduates' register confirmed that the Edmonton enrolment had decreased.[591] It is evident that in this instance the sisters referred to the place of residence prior to enrolment. Based on this, and on the geographical distribution of the students it appears that after the mid 1930's the location listed was thus more than likely the place of residence immediately prior to enrolment. Although the lack of precision of the register is a problem, it is believed that overall it provided an appropriate source of information to establish the place of origin of the graduates.

The register was also used to try to determine the composition of graduating classes in terms of the proportion of Franco-Albertans in them. Determining this was important because it provided an indication of the place of the hospital in the Franco-Albertan community. In order to determine which students were French Canadian the list was examined and all subjects with French surnames were classified as belonging to this group. This method has a number of limitations but it was the only one that could be used other than consulting the few newspaper clippings available in the Franco-Albertan press. One of the limitations is that bearing a French surname does not necessarily mean that the individual is French Canadian in the sense in which it is used in this study; i.e. speaks French, comes from a family whose members perceives themselves as members of the French Canadian community and where French Canadian values and traditions are transmitted. Conversely, having a surname which is not French does not eliminate the possibility that an individual may be in fact predominantly French Canadian. For example, this situation can occur in marriages where the mother is French Canadian and the father from another cultural group. It is evident that subjects such as these could not be identified by the method utilized. Inter cultural marriages has long been considered an important factor leading to the assimilation of Franco-Albertans into the dominant ethnic group. It is common knowledge that this type of marriage has increased over time. Thus the likelihood that a student identified as French Canadian was indeed French Canadian is greater if she graduated in the 1920's rather than in the 1950's. Information found in newspapers confirmed that many subjects identified as French Canadians seemed to be from that cultural group, and that the geographical distribution of the subjects identified as French Canadians increased the likelihood that they belonged to this group and still spoke French. Finally, the large proportion of graduates with French surnames during the years of affiliation with *Collège Saint-Jean* suggests that the method of identification has some validity.[592]

---

[591] Statistics are provided elsewhere.

The same method could have been utilized to determine the ethnic origin of other graduates of the EGH. However, since the focus of this study is primarily on Franco-Albertans other groups were not studied to the same extent. Aside from English appearing surnames, a perusal of the data revealed a significant number of slavic surnames. The origins of these students are briefly addressed at the end of this section.

Place of origin of the graduates of the EGH School of Nursing

Results presented in Table 59 show that 1,999 nurses graduated from the EGH school of nursing between 1911 and 1973. Slightly more than 80% of these students were from Alberta. Significantly, 9.55% of the graduates were from the neighbouring provinces of Saskatchewan and British Columbia. Only two percent of the students were from other provinces or countries. It is thus very likely that students for whom a place of origin could not be established (8.05% of the sample) were from either Alberta or its neighbouring provinces. Each province or country of origin is addressed separately in the following pages. However, a more detailed analysis is provided about the place of origin of graduates from Alberta.

---

[592] From 1968 until 1973, the EGH School of Nursing was affiliated with the *Collège*, an institution predominantly serving the French speaking population of Alberta.

TABLE 59

PLACES OF ORIGIN OF THE GRADUATES OF THE EGH SCHOOL OF NURSING

Place of origin	n (%)
Alberta	1607 (80.39)
Saskatchewan	166 (8.30)
British Columbia	25 (1.25)
Manitoba	12 (0.60)
Quebec	10 (0.50)
Other provinces	8 (0.40)
Other country	10 (0.50)
Unknown	161 (8.05)
TOTAL	1999 (100.00)

Graduates from Alberta

The results presented in Table 60 provide information about the region of origin of the 1,607 graduates who were from Alberta. The number of students by region was determined by locating each town of origin on an Alberta road map.[593] Towns were then grouped into ten geographic areas. These areas were delineated in order to provide a suitable representation of the geographical distribution of the graduates. Edmonton was considered as one area since it was the location of the EGH and the most common city of origin. Edmonton suburbs were grouped in a square area having as limits four towns located approximately 50 kilometres away from Edmonton's city centre. The northern limit was Legal, the eastern limit was Lamont, the southern limit was Millet and the western limit was Edmonton Beach. Because a square system was utilized some towns enclosed in the area may have been at far away as approximately 70 kilometres from the city centre. This square was then enlarged to draw cardinal directions limits of 51 to 150 kilometres from Edmonton's city centre. Therefore a town enclosed in this area could not be more than 210 kilometres away from Edmonton. The most important centres which were located on the 150 kilometres limit in the four cardinal points were Plamondon (north), St. Paul (east), Red Deer (south) and Whitecourt (west). Another category was made of all towns located less than 100 kilometres away from the Saskatchewan border. In terms of latitude, most of the towns of that area were north of Red Deer or south of Bonnyville.[594] The central area included all locations south of Red Deer but north of Calgary and east of Rocky Mountain House but west of Stanmore (Stanmore is on the same longitude as St. Paul, thus more than 100 kilometres away from the Saskatchewan border). The Calgary and south area included Calgary and every location further south (limit United States border) and which were within the same longitudinal limits as the central area. The areas labelled as Peace River country, Jasper and Banff area, Slave Lake area correspond to the geographical areas commonly considered when using these terms.[595] Finally, the northern area included only three locations found in the northern part of the province.[596]

---

[593] Alberta Tourism, ***Province of Alberta official road map - 1986***, (Edmonton: author, 1985).

More than 75% of the students were from areas within the boundaries of the Edmonton greater area. This is not surprising since this part of the province has a greater population density than many of the other regions. In addition, it was expected that fewer students would have come from towns located south of Red Deer since these sites are much closer to Calgary than Edmonton. It is logical that students from these areas would have favoured Calgary's schools of nursing. Accordingly, the large representation of the Peace River and Saskatchewan border areas can be seen as normal since Edmonton is the closest large urban centre. Similarly, most of the students from the Banff and Jasper areas came from areas located closer to Edmonton than from Calgary.

---

[594] Only five students were from towns south of Red Deer's longitude, and two were from locations north of Bonnyville's longitude.

[595] The important centres of these areas are: Peace River (484 km from Edmonton), Grande Prairie (455 km from Edmonton), Banff (401 km from Edmonton), Jasper (262 km from Edmonton) and Slave Lake (251 km from Edmonton).

[596] Atikameg (300 km north from Edmonton), Fort McMurray (431 km from Edmonton) and Highlevel (738 km from Edmonton).

TABLE 60

REGIONS OF ORIGIN OF GRADUATES OF ALBERTA

Region or city	n (%)	n of towns
Edmonton	550 (34.23)	1
Edmonton area	125 (7.72)	27
Edmonton greater area	542 (33.73)	141
Saskatchewan border area	161 (10.02)	55
Peace River country	106 (6.60)	31
Calgary and south	53 (3.30)	18
Central area	37 (2.30)	20
Banff and Jasper area	24 (1.49)	7
Slave Lake area	5 (0.31)	3
Northern area	4 (0.25)	3
TOTAL	1607 (100.00)	306

Overall, it is apparent that graduates came from all areas of the province and that a significant number of them were from very small towns, since 306 towns were identified and since Alberta had only few large centres existing in the early years, as in 1994. To some extent the number of students who came from each of the 306 towns paralleled the size of these municipalities. Four hundred thirty graduates were from 249 towns generating one to four graduates each, 182 were from another set of 27 towns generating five to nine graduates, and the remaining 995 Albertans were from 30 towns generating between 10 and 550 graduates. The results presented in Table 61 give a list of all towns which generated more than ten graduates. At least four factors need to be considered when trying to understand why a relatively large number of graduates were from these towns; size over time, proximity to Edmonton, presence or absence of other schools of nursing in the area and ethnicity/religion.

TABLE 61

ALBERTA COMMUNITIES GENERATING TEN OR MORE GRADUATES

Town or city	n	Total
Edmonton	550	550
Red Deer	37	37
Wetaskiwin	23	23
Camrose and Lloydminster	22	44
St. Albert	21	21
St. Paul	20	20
Legal	19	19
Lethbridge	18	18
Vegreville	17	17
Daysland and Ponoka	16	32
Calgary	15	15
Falher and Heisler	14	28
Grande Prairie, Lacombe, Mundare, Stony Plain and Westlock	13	65
Fort Saskatchewan	12	12
Clyde, Leduc, Morinville and Myrnam	11	44
Consort, Fairview, Stettler, Vermillion and Wainright	10	50
TOTAL NUMBER OF SUBJECTS		995

Abbreviation used: number of subjects by town or city (n).

Using 1993 as a time referent, it is apparent that most of the largest urban centres of Alberta are on the list. This is not surprising since most of these centres are fairly old and were important ones for most of the years under study. However, others such as Medicine Hat and Fort McMurray are not included while small towns such as Falher and Myrnam are among those listed. In fact, these four towns provide good examples of how the factors which affected enrolment came into play. Although Medicine Hat has been a prominent town since the 1890's, it is, however, much closer to Calgary than Edmonton, and the first formal school of nursing in the province was established in that town in 1894. In contrast, Fort McMurray which is much closer to Edmonton than Calgary did not have a school of nursing. However, it was only during the 1950's that it gained in size and importance. Falher and Myrnam have much in common; neither currently have or had in the past schools of nursing and both are closer to Edmonton than Calgary. Based on today's criteria, they are small towns. However, in earlier days they were centre for significant *colonies* of cultural groups from which came many graduates from the EGH.

In the 1910's French Canadians began to settle the Peace River area and Falher, which was founded in 1912, was one of the first villages created in the region.[597] In fact, for Franco-Albertans, Falher is still an important town even if it has remained a small municipality. Similarly, during the same period of time (1910's) Myrnam became an important Ukrainian village which also attracted settlers from other Eastern European countries such as Poland and Romania.[598] It is evident that the large number of Ukrainian, Polish and French Canadians among the EGH graduates explains why more than ten graduates came from these towns. Ten of the 14 graduates from Falher were French Canadians, while eight of the eleven graduates from Myrnam were of slavic origin.[599]

---

[597] Donald Smith, "A history of French speaking Albertans", in ***Peoples of Alberta - Portraits of cultural diversity***, ed. Howard Palmer and Tamara Palmer, (Saskatoon: Western Producer Prairie Books, 1985), 91.

[598] Frances Swyripa, "The Ukrainians in Alberta," Ibid., 218.

Another interesting aspect of the Alberta sample is that a large percentage of graduates (65.77%) were not from Edmonton. It thus appears that the EGH School of Nursing played an important role in educating nurses from rural areas. When the graduates from other provinces are included, and particularly when the places of origin of Saskatchewan graduates are examined, the role of the school in respect of rural areas becomes even more obvious.

Graduates from Saskatchewan

One hundred sixty-six (8.30%) graduates were from Saskatchewan (see Table 59).[600] One hundred forty-one graduates (84.94%) were distributed among 65 towns of origin all west of Saskatoon or at the same longitude. The remaining 25 students were from 20 towns located east of Saskatoon. Only eight towns generated five or more graduates, all west of Saskatoon. Eight graduates were from North Battleford and Wilkie, six were from Luseland; Biggar, Goodsoil, Kerrobert, Macklin and Unity were each the places of origin of five graduates. North Battleford, being the most important urban centre west of Saskatoon (excluding Lloydminster since it straddles the border between Alberta and Saskatchewan), was understandably the most common town of origin. These results also show that proximity to Alberta increased the likelihood that Saskatchewan women chose to study at the EGH. The small number of nursing schools in Saskatchewan may explain why a relatively large number of students came to the EGH for their nursing education. It certainly would have been interesting to know the degree to which Saskatchewan students were attracted by other schools of nursing in Alberta, especially since 30 of the 65 students who came from "western" Saskatchewan were from towns closer to Calgary than Edmonton.

---

[599] Although people from Poland are not strictly speaking of slavic origin, it is common to consider them as members of that group.

[600] Based on the years for which places of origin were known, there were only seven years, all prior to 1925, during which none of the graduates came from Saskatchewan; towns in Saskatchewan were located using a road map of the province: Canadian and American Automobile Association, ***Road map of Manitoba and Saskatchewan***, (Heathrow, Florida: author, 1990).

Graduates from British Columbia

Although only 25 graduates (1.25%) were from British Columbia, it is of interest to examine their regions of origin.[601] Eleven (44%) were from towns located in the Rocky Mountains and three (12%) from towns near the Alberta Peace River country. Thus, 56% of the British Columbia graduates were from towns very close to the Alberta border. In addition, five graduates came from the Okanagan valley and two from the Prince George area, both at least as close to Alberta than from the West Coast where the large schools of nursing in that province were located.[602] It is thus apparent that geography was also an important factor for this group of graduates.

Graduates from other provinces or countries

Twelve graduates were from Manitoba, ten from Quebec, seven from Ontario and one from Nova Scotia (see Table 59). It is important to mention that eight graduates from Quebec were Grey Nuns and that one from Manitoba also belonged to the order.[603] Ten graduates were from other countries. Seven were from the United States, one from England, one from Poland and one from the British West Indies (Barbados). The graduate from the latter country specifically came to Canada to study nursing and was the only student from a foreign country who graduated after 1930.[604] Excluding this individual, and three of the Americans[605], it appears that the other graduates who were not from Canada must have come from families who had settled in

---

[601] A British Columbia road map was used to locate their towns of origin, British Columbia Tourism, ***Official British Columbia road map***, (Victoria: author, 1991).

[602] Only four students came from the West Coast.

[603] The graduates of the EGH included 13 Grey Nuns and four sisters of other orders. One of the 13 Grey Nuns did not work at the EGH prior to 1970. This explains why she is not included in the number of graduates reported in Chapter 11.

[604] She graduated in 1961 and was the first black student. ASGME, EGH, History of the school of nursing file, 1961.

[605] These three Americans were Grey Nuns.

Alberta.

French Canadian graduates

Three hundred eighteen graduates were identified as French Canadians. They comprised 15.90% of the total sample of graduates. The results presented in Table 62 show the province or country of origin of these individuals. It is of interest that the only male graduate from the EGH school of nursing was French Canadian and that he completed his studies in 1943. It is thus quite probable that he was a member of the Canadian Armed Forces.[606]

TABLE 62

PLACES OF ORIGIN OF THE
FRENCH CANADIAN GRADUATES

Place of origin	n (%)
Alberta	241 (75.79)
Saskatchewan	21 (6.60)
Quebec	9 (2.83)
Other provinces	6 (1.89)
United States	1 (0.31)
Unknown	40 (12.58)
TOTAL	318 (100.00)

Franco-Albertans

Two hundred forty-one graduates from 68 towns were Franco-Albertans. Considering that these students comprised 14.99% of the Alberta graduates and that since 1901, Franco-Albertans have always constituted less than 7% of the provincial population it appears that the EGH School of Nursing probably attracted more Franco-Albertans than any other school of the province.[607] The fact that Franco-Albertans viewed the EGH as a French Canadian institution probably explains why a significant number of them selected to study nursing at that hospital.[608]

---

[606] His place of origin could not be established.

TABLE 63

ALBERTA REGIONS OF ORIGIN OF FRENCH CANADIAN GRADUATES

Region	n of students (%)	n of towns
Edmonton	137 (56.85)	15
Peace River	35 (14.52)	11
St. Paul's	29 (12.03)	7
Other	40 (16.60)	35

The results presented in Table 63 show the regions of origin of the Franco-Albertan graduates. It appears that a little more than 83% of them came from three regions which have traditionally attracted French Canadian settlers. A more detailed analysis revealed that the students from each region predominantly came from towns or cities where there were clusters of Franco-Albertans. In the Edmonton area 127 graduates (92.70%) out of 137 came from either Edmonton (93 graduates), Legal (11 graduates), Morinville (eight graduates), St. Albert (five graduates), Vimy (four graduates), and Beaumont, Villeneuve or Lamoureux (two graduates each). Similarly, 29 (82.86%) of the 35 graduates from the Peace River area were from towns first settled by French Canadians: Falher (10 graduates), Grande Prairie and McLennan (five graduates each), Girouxville (four graduates), Donnelly (three graduates), and Guy and

---

[607] In 1901 Franco Albertans comprised 6.18% of Alberta's population while in 1981 they were only 5.05% of the population. These percentages are based on Canadian census figures; Howard Palmer and Tamara Palmer, ***Peoples of Alberta - Portraits of cultural diversity***, (Saskatoon: Western producer Prairies Books, 1985), XVI.

[608] The link between the EGH and the Franco-Albertan community is further addressed in Chapter 16.

Peace River (one graduate each).[609] Accordingly, 24 (82.76%) of the 29 graduates of the St. Paul area were from St. Paul (15 graduates), Bonnyville (four graduates), Lac La Biche and Lafond (two graduates each) and Duvernay (one graduate).

TABLE 64

MOST COMMON PLACES OF ORIGIN
OF FRENCH CANADIAN GRADUATES

Town or city	n (N)
Edmonton	93 (550)
St. Paul	15 (20)
Legal	11 (19)
Falher	10 (14)
Morinville	8 (11)
Grande Prairie	5 (13)
McLennan	5 (9)
St. Albert	5 (21)
Bonnyville	4 (6)
Girouxville	4 (4)
Vegreville	4 (17)
Vimy	4 (6)
Dollard, Sask.	4 (4)
TOTAL	167

Abbreviations used: number of French Canadians (n),
total number of graduates (N).

The results presented in Table 64 give the number of graduates from the most common towns or cities of origin of the French Canadian graduates. For nine of these towns French Canadian subjects comprised at least 55% of the graduates from that town. Eight of the locations found in Table 64 were among Alberta towns which generated more than ten graduates (see Table 61). Interestingly, five of these would have produced fewer than ten graduates if Franco-Albertans had not been part of the sample.[610]

---

[609] Franco-Albertans use the term *Rivière-la-Paix* when referring to Peace River.

Fransaskoises[611]

Twenty-one graduates (6.60%) were *Fransaskoises*. Similarly to other graduates from Saskatchewan most of them were from towns located west of Saskatoon (17 towns out of 21 were west of that city). It is of interest that 14 (66.67%) of the 21 graduates came from towns which have been recognized as common places of origin for *Fransaskois*.[612] Four of them were from Dollard; Biggar, North Battleford, Prince Albert and Rosetown each generated two graduates; and Edam and Gravelbourg were the home of one graduate each.

Other provinces or country of origin

Ten of the 16 graduates who were not from Alberta or Saskatchewan belonged to the Grey Nuns Order. Eight were from Quebec, one from Manitoba and one from the United States. The remaining six graduates were from north-east British Columbia (two graduates), Ontario (two graduates), Manitoba (one graduate) and Quebec (one graduate).

French Canadian graduates over time

The results presented in Table 65 show that the number of French Canadian graduates increased over time but that the percentage of graduates of these origins was fairly stable over time. However, when the years in which *Collège Saint-Jean*[613] was involved in the EGH School of Nursing program are singled out, the percentage of French Canadian graduates is significantly greater. Thirty-four (25.95%) of the 131 graduates of 1970 to 1973 were French Canadians.[614] This increased percentage explains why the proportion of French Canadian graduates in the 1958 to 1973 period was greater than in any other period of time. However, the issue is to know if the greater percentage was due to a net increase in the total number of French Canadian subjects, or if it was due to a decline in the number of students from other nationalities, or to both factors at once. In order to address this issue, data from the last four classes prior to the association with *Collège Saint-Jean* was compared with data of the four years in which the school of nursing was linked with that institution. The comparison showed that from 1967 to 1970, 28 graduates were French Canadian and 142 from other nationalities. In contrast, from 1970 to 1973, 34 graduates were French Canadian and 97 from other nationalities.[615] It is thus evident that during the years of affiliation with

---

[610] St. Paul, Legal, Falher, Morinville and Grande Prairie would have been excluded.

[611] A *Fransaskoise* is a French Canadian woman from Saskatchewan.

[612] André Lalonde, "Les canadiens français de l'ouest: espoirs, tragédies, incertitudes," in ***Du continent perdu à l'archipel retrouvé - le Québec et l'Amérique française***, ed. R. Louder and Eric Waddell, (Quebec: Presses de l'Université Laval, 1983), 86.

[613] *Collège Saint-Jean* was at the time a bilingual college operated and owned by the Oblate priests. Importantly, it offered courses which were at the baccalaureate level.

TABLE 65

NUMBER AND PERCENTAGE OF FRENCH CANADIAN GRADUATES BY TIME PERIOD

Period of time	n (%)	N
1911-1918	12 (15.79)	76
1919-1938	59 (13.56)	435
1939-1957	98 (14.02)	699
1958-1973	149 (18.88)	789
TOTAL	318 (15.90)	1999

Abbreviations used: number of French Canadian graduates (n) and total number of graduates (N).

---

[614] 28.75% in 1970, 16.13% in 1971, 27.02% in 1972 and 30.95% in 1973.

[615] There were two graduating classes (one in each program) in 1970. This explains why 1970 is listed twice.

the *Collège* that the number of graduates from other nationalities significantly declined while the number of French Canadian graduates marginally increased. It thus appears that the increased percentage of French Canadians was in large part due to a decline in the number of students from other nationalities. Therefore, the affiliation with a bilingual college meant that some of the courses were offered in French and may have been a deterrent for the unilingual English speaking majority. The fact that the number of French Canadian graduates only slightly increased may be related to the pool of available candidates. The EGH School of Nursing had always attracted Franco-Albertans and it is possible that it was already drawing most of candidates wishing to become nurses. The allegiance to the school, which was probably related to culture, religion and language is further demonstrated by the fact that Franco-Albertan enrolment did not decrease during the years of affiliation with *Collège Saint-Jean*.

Graduates of Eastern-European origin

One hundred thirty-seven graduates had surnames suggestive of a slavic origin.[616] Most of these graduates must have been from Ukrainian or Polish descent, since the number of settlers from other Eastern-European countries has always been marginal.[617] Using the work of Matejko and Swyripa[618] it was possible to confirm that 65 (47.4%) of these graduates were from eastern central Alberta which was the traditional area of settlement for the first waves of immigrants from Eastern Europe.[619]

---

[616] These graduates were from 56 towns of Alberta, 9 towns of Saskatchewan, and an unknown location in Poland.

[617] It was impossible to determine with accuracy the number of students of each nationality. However, 46 graduates had surnames ending by "sky" which suggests Polish nationality, and 21 had surnames ending by "chuk" which usually indicates Ukrainian origins.

[618] Joanna Matejko, "The Polish experience in Alberta," in ***Peoples of Alberta - Portraits of cultural diversity***, ed. Howard Palmer and Tamara Palmer, (Saskatoon: Western Producer Prairie Books, 1985), 274-296; Frances Swyripa, "The Ukrainians in Alberta," Ibid., 214-242.

[619] Three towns generated more than three graduates: Myrnam and Willingdon had six each and Mundare had four.

Edmonton also attracted many people of these origins. It is thus not surprising that 41 graduates were from that city. Therefore, 106 students or 77.37% came from the two most common areas of settlement for people of slavic origin. Some of the remaining graduates of this group were also from towns which, although outside the main areas of settlement, were established and populated by significant numbers of Polish and Ukrainian immigrants.[620]

Excluding one Polish graduate (she was the graduate born in that country) who completed her studies in 1919 all other slavic graduates began their nursing studies after 1922.[621] Considering that the first wave of immigrants from Eastern Europe came to Alberta in the 1890's it appears that daughters of the first Canadian born generation chose to study nursing at the EGH. It may be suggested that the fact that the EGH was a Catholic hospital may have been appealing for many, since most Polish immigrants and many Ukrainians belonged to that church.

Graduates from Edmonton

The results presented in Table 66 clearly show that the percentage of Edmontonians was much greater in the last fourteen years for which data was available. It may be suggested that this increased in proportion was probably linked to the fact that during these years, Alberta was becoming increasingly urban. Based on the results presented in Table 66, it also appears that the percentage of Edmonton graduates was fairly stable for the first three periods of time. However, a more indepth examination of the data revealed that in 15 graduating classes less than 20% of the graduates were from Edmonton and that 14 of these classes graduated between 1924 and 1954. It was noted that the percentage of attrition was also greater during these years.[622] Unfortunately, records related to attrition did not include information about towns of origin. However, there was no reason to believe that attrition would have been significantly greater among Edmontonians. It thus seems that the relatively low percentage of graduates from Edmonton must have been the product of low enrolment. In fact, the construction questionnaire of 1939 revealed that the sisters had noted that the number of Edmontonians enroling in the program was small.[623] Although the sisters stated that they believed Edmontonians preferred the schools of other Edmonton hospitals because more varied clinical experiences could be provided at these institutions, they did not indicate the point at which this phenomenon had been noticed. The purpose of the document might explain why they did not mention other factors which might have been linked to the phenomena and why little details were provided. However, for the purpose of this analysis it is necessary to further examine this issue.

---

[620] For example, two Ukrainian graduates were from Rycroft (in the Peace River area), and three Polish graduates were from Lethbridge.

[621] The first Ukrainian subject graduated in 1925 and the second Polish graduate was a member of the class of 1933.

[622] Attrition is addressed elsewhere in this chapter.

TABLE 66

NUMBER AND PERCENTAGE OF GRADUATES FROM EDMONTON BY TIME PERIOD

Period of time	n (%)	N
1916-1918	8 (24.24)	33
1919-1938	92 (21.14)	435
1939-1957	162 (23.17)	699
1958-1971	288 (40.56)	710
TOTAL	550 (29.30)	1877

Abbreviations used: number of graduates from Edmonton (n), total number of graduates (N).

Providing an analysis based on graduates is not ideal, and the lack of information about other schools constitutes a limitation. Yet, the available data contains information which may be used to propose further reasons which may be related to the small number of Edmonton students. It is believed that the availability of varied clinical experiences was probably a factor. However, it is also reasonable to suggest that the fear of tuberculosis, the age and condition of the physical facilities, the provision of monthly allowances, and to a lesser degree, a conflict between students and the school which occurred in 1929 may also have contributed to the small enrolment of Edmontonians. These factors came to mind when it was noted that eight of the classes with less than 20% of graduates from Edmonton graduated between 1932 and 1942 and that in this period of time there were even two years (1936, 1942) in which none of the graduates were from Edmonton. Based on these observations, graduating classes were grouped into a new "time period" classification designed to isolate factors as much as possible. The resulting periods of time and corresponding percentages are presented in Table 67. However, the significance of the results of this Table cannot be assessed unless the characteristics of each period of time are individually described.

---

[623] ASGME, EHH, Doc. 155, 14 January 1939; see Chapter 9 for more information about this document.

TABLE 67

PERCENTAGE OF GRADUATES FROM EDMONTON
BETWEEN 1924 AND 1962

Period of time	Percentage	n of classes with less than 20% of graduates from Edmonton
1924-1931	29.73%	3
1932-1942	12.99%	8
1943-1954	22.78%	3
1955-1962	33.72%	1

The years 1924 to 1931 were grouped together because the graduates of 1924 began their studies when the 1921 building was opened. This meant that the number of hospital beds was sufficient when they enrolled in the program and that a large portion of the institution was new and attractive. It was decided to conclude the period with the year 1931 because the graduates of that class were the last ones to be admitted before the economic crash of 1929. After the latter, the patient censuses were significantly lower. Importantly, it is logical to believe that a smaller bed occupancy would have diminished the availability of varied clinical experiences. It must be noted that the tuberculosis departments did not exist between 1924 and 1931. Therefore, none of the suggested deterrent factors were present during this period of time. Incidently, the percentage (29.73%) of Edmontonians was elevated in comparison to the percentage of subsequent years.

The conditions were much different for the period of 1932 to 1942. The graduates of 1932 had enrolled after the economic crash and the graduates of 1942 were the last ones who had started their program before the opening of the "1940 wing". In fact, every deterrent factor came into play during these years. The variety of clinical experience was curtailed by a low patient census and the presence of a large tuberculosis section from 1936 onward.[624] In particular, the creation of the large TB service resulted in the closure of the maternity department. The fear of contracting tuberculosis must have also been real for many students and it must be noted that the EGH was the only Edmonton hospital which admitted large numbers of patients who had that disease. In addition, in 1929, a conflict between the students and the hospital administration had been made public in the local press.[625] It is thus possible that some potential students from Edmonton may have been negatively influenced by this event. The effect would probably have been momentary but, nevertheless, it needs to be taken into account. It is notable that there was no new building or new construction work undertaken during these years and fire regulations had imposed the closure of a number of units. In contrast, new facilities had been built at the other Catholic hospital of the city (the Misericordia Hospital). A new student residence had been inaugurated in 1936 and a state of the art maternity service had opened in 1940.[626] The absence of a monthly allowance may have also been a deterrent. Although it is not known when other institutions of Edmonton began to provide such allowances, it was found that the RAH provided one as early as 1935.[627] Consequently, it is not surprising that between 1932 and 1942, the EGH School of Nursing had the smallest percentage (12.99%) of Edmonton graduates in its history.

---

[624] The overall effect of the economic depression in terms of specific enrolment issues is presented elsewhere.

[625] This conflict is fully addressed elsewhere in this chapter.

[626] John Gilpin, ***The Misericordia Hospital***, 79 and 89.

The graduates of the next cohort (1943-1954) enrolled after the opening of the "1940 wing" and before the closure of the TB service (in 1952). It must be stated that in addition to the 1940 expansion a temporary medical ward was constructed in 1948. Thus, the availability of varied clinical experiences was greater than in the previous period of time since new facilities had been constructed. In addition, a monthly allowance was introduced in 1943.[628] As expected the percentage (22.78%) of Edmontonians was much greater than between 1932 and 1942, even though it was still lower than between 1924 and 1931. In the last period of time, 33.72% of the graduates were from Edmonton. The shift to a more urban society may have contributed to this increase. However, it must be noted that the TB service was no longer in operation and that new facilities had opened in 1953. It thus seems that once all identified deterrents were gone the EGH school began to attract more students from Edmonton. Consequently it appears that the rate of enrolment of Edmontonians might have been linked to the factors which were identified at the beginning of this analysis.

In contrast, students from rural areas were in a different situation because their knowledge of the conditions which existed in the various schools of nursing of the city was probably more limited. This may in part explain why a large number of them continued to enrol at the EGH. The above data confirmed that for many years few Edmontonians graduated from the EGH school. However, what remains unknown is the proportions of city and rural students in the competing schools and it is only through similar analysis of their enrolment that it would be possible to confirm that they attracted more city students and consequently fewer students from rural areas.

---

[627] Christina Dorward and Olive Tookey, ***Below the flight path***, (Edmonton: Commercial Printers Limited, 1968), 12.

[628] ASGME, EGH Historique de l'école (EGHS), 1943.

The growth of the EGH School of Nursing

Almost 2,000 students graduated from the EGH school of nursing between 1911 (first class, had six graduates) and 1973 (last class had 42 graduates). The results presented in Table 68 provide details about the number of graduates over time and can be used as an indication of the growth of the school. It can be seen that the number and mean number of graduates per class almost always increased between 1911 and 1968.

TABLE 68

STATISTICS ABOUT GRADUATES
BY TIME PERIOD

Period of time	n	$\bar{x}$	s	Smallest class (year)	Largest class (year)
1911-1918	76	9.5	6.9	4 (1912)	21 (1914)
1919-1928	174	17.4	8.7	4 (1919)	31 (1928)
1929-1938	261	26.1	6.5	18 (1932)	35 (1931)
1939-1948	299	29.9	9.7	16 (1942)	48 (1948)
1949-1958	462	46.2	8.6	32 (1949)	62 (1958)
1959-1968	513	51.3	7.2	42 (1968)	61 (1965)
1969-1973	214	35.7	10.9	21 (1970)	53 (1970)

N.B. There were two groups graduated in 1970. The last group of the three year program and the first group of the two year program.

It was noted earlier that the number of graduates from Edmonton was very small between 1932 and 1942 and that the classes of 1936 and 1942 did not have a single graduate from the city. The results presented in Table 68 show that these two years had the smallest total number of graduates within the periods of time in which they were classified. Understandably, the absence of Edmonton graduates may have had an effect on the size of these two classes. However, while the number of Edmontonians remained low during the other years of these periods, the total number of graduates was not significantly lower. On the contrary, the results show that the average number of graduates increased in comparison to the average of previous periods of time. It is therefore evident that a comparatively larger percentage of graduates must have been from rural areas since the number of graduates did not decrease. It also means that since the numbers of graduates were much lower than normal in 1936 and 1942 that the number of graduates from rural areas had to be smaller at that time. The small number of graduates in 1942 is difficult to explain. However, the low number of graduates in the class of 1936 was more than likely related to the economic depression. Indeed these graduates had enrolled in 1933, one of the worst years of the crisis in Alberta. Data on students' enrolment showed that it was also the year in which the smallest number of students came to study at the EGH.[629] As a whole, the fact that the number of graduates did not significantly decrease during the depression years is rather interesting. Results presented elsewhere show that in fact enrolment increased during the depression. It is highly probable that charitable motives may have incited the sisters to accept larger numbers of students and that similarly, some rural families may have considered it advantageous to send a daughter to the EGH school. The words of Alvine Cyr Gahagan, a graduate of 1932, lend support to this hypothesis. The crash of 1929

> ... affected many of our parents. Edmonton being a farming district, these people found it hard; they could not sell their products. Skilled people could not find jobs of their chosen professions. We in training felt that we were lucky; we worked hard and studied hard, but the sisters fed us well. I can still see those tray-like table tops, with gallons of cream and milk for all the cereal that we wanted. I remember puffed wheat and rice, yes, and the famous porridge, "oatmeal". Then, for lunches, they would put out a whole pound of butter at a time, with two or three kinds of jam; sometimes the whole can was there, and the same with peanut butter. I remember making sandwiches with all these in them - was that ever good. These were our lunches in the morning at 10 o'clock

---

[629] Enrolment figures were calculated by adding the number of students who left the program to the number of graduates. The topic is further addressed in the section on attrition.

> and the evening snacks. These were beside our three full meals. No wonder when I would come to the lunch counter I would say, "no potatoes, please, Sr. Chauvin", ...[630]

The results of Table 68 show that the actual and mean numbers of graduates per class were smaller between 1969 and 1973 than they were in the previous period of time. The decrease in the total number of graduates had to be smaller than in the previous period since a smaller number of classes were part of this period of time. However, the lower mean number of graduates indicates that enrolment did decrease. Part of this decrease may be explained by the beginning of the two-year program in 1968. Potential students may have selected to enrol in schools where less change was taking place. In addition, it has been shown that the fact that much of the instruction was given at *Collège Saint-Jean* may have been a deterrent for some unilingual English speaking students. However, other factors must be taken into account. In particular, the data showed that the number of graduates began to decrease after 1965. That year there were 61 graduates, while during the following five years there was a gradual decline from 46 in 1966 to 30 in 1969. Interestingly, there were 53 graduates in 1970 (only the three year program graduates are included here). It is possible that a small proportion of the decline of the late 1960's may have been related to the beginning in 1966, of the integrated basic baccalaureate program of the University of Alberta. This program may have been particularly appealing to those who considered that going to university was their first priority. The young women of the 1960's were also increasingly drawn to other fields than nursing. In a report submitted to the Royal Commission on Health Services, Mussallem wrote: "In absolute terms, the number of students entering schools of nursing has increased during the past two decades. However, in relative terms the percentage of high school graduates entering schools of nursing has declined."[631]

---

[630] Alvine Cyr Gahagan, ***Yes father, Pioneer nursing in Alberta***, (Manchester, N.H.: Hammer Publications Inc., 1979), 67.

[631] Helen K. Mussallem, ***Nursing education in Canada - Royal Commission on Health Services***, (Ottawa: Queen's Printer, 1965), 22.

Therefore, it is possible that the decrease in enrolment noted at the EGH school was a reflection of national trends and thus not only related to internal factors in the institution.

Attrition at the EGH School of Nursing

Available data permitted establishing the level of and reasons for withdrawal[632] in the classes which graduated between 1922 and 1965.[633] The sisters used a class system to record withdrawal information. Because of this, it was possible to estimate the year during their period of study when students had left the program.[634] Presenting the data in this manner seemed to be more meaningful than using the regular calendar system. In particular, it allowed examination of whether or not there were links between the reasons for withdrawal and when students were leaving.

Withdrawals over time

At least 1,825 students enrolled at the EGH school of nursing between 1919 and 1962. Of these, 384 or 21.04% never completed their studies. The results presented in Table 69 and 70 provide statistics about withdrawals per year of study by point in the program when withdrawals occurred. The results presented in Table 69 show that the highest percentage (28.09%) of withdrawals occurred from 1932 to 1941 and that the lowest (11.11%) was found between 1962 and 1965.

---

[632] Attrition and withdrawal have the same meaning in this analysis. They mean any departure from the program (voluntary or not).

[633] All statistics presented in this section were based on information found in a ledger kept in the Grey Nuns archives and entitled: *Summary of the school of nurse's enrolment 1908-1971*. Information on withdrawal was not available for the classes which graduated before 1922, and the information provided after 1965 was too unclear to be utilised. In addition, data was not available for the graduating classes of 1923, 1924, 1927 and 1952. Entries were handwritten and the changes in the handwriting indicated that the data was entered on a regular basis over time.

[634] The calculation method is best explained by using an example. If the class of 1922-1925 is used, it can be deduced that all students who left in 1922 were in their first year of study. Those who departed in 1923 were either in the first or second year of the program. Similarly, students who left in 1924 were either in second or third year, while those who departed in 1925 were necessarily in their third year of study.

TABLE 69

NUMBER AND PERCENTAGE OF WITHDRAWALS PER YEAR IN FUNCTION OF ENROLMENT BY TIME PERIOD

	1922-1931	1932-1941	1942-1951	1952-1961	1962-1965	TOTAL
n in 1 (%)	22 (9.17)	43 (12.99)	51 (11.26)	48 (8.60)	8 (3.29)	172 (9.43)
n in 1 or 2 (%)	23 (9.58)	33 (9.97)	39 (8.61)	34 (6.09)	13 (5.34)	142 (7.78)
n in 2 or 3 (%)	1 (0.42)	15 (4.53)	19 (4.19)	12 (2.15)	4 (1.65)	51 (2.79)
n in 3 (%)			1 (0.22)	4 (0.72)	2 (0.82)	7 (0.38)
n in ?	10 (4.16)	2 (0.60)				12 (0.66)
Total n	56 (23.33)	93 (28.09)	110 (24.28)	98 (17.56)	27 (11.11)	384 (21.04)
Enrolment	240	331	453	558	243	1825

Percentages are based on enrolment and should be read vertically. Abbreviations used: number of withdrawals (n), during the first year of the program (in 1), during the first or second year (in 1 or 2), during the second or third year (in 2 or 3), during the third year (in 3), year of the program unknown (?).

TABLE 70

NUMBER AND PERCENTAGE OF WITHDRAWAL PER YEAR OF OF STUDY BY TIME PERIOD

Period of time	year 1 and year 1 or 2, n (%)	year 2 or 3 and year 3, n (%)	year unknown n (%)	Total n (%)
1922-1931	45 (80.36)	1 (1.78)	10 (17.86)	56 (100.00)
1932-1941	76 (81.72)	15 (16.13)	2 (2.15)	43 (100.00)
1942-1951	90 (81.82)	20 (18.18)		110 (100.00)
1952-1961	82 (83.67)	16 (16.33)		98 (100.00)
1962-1965	21 (77.78)	6 (22.22)		27 (100.00)
TOTAL	314 (81.77)	58 (15.10)	12 (3.13)	384 (100.00)

Percentages are based on withdrawals and should be read horizontally. Abbreviations used: number of withdrawals (n), during the first year of the program (in 1), during the first or second year (in 1 or 2), during the second or third year (in 2 or 3), during the third year (in 3), year of the program unknown (?).

Attrition has always been noted in North American schools of nursing. For example, Reverby reported that in 1897, 24% of the students enrolled in Massachusetts schools of nursing left before completion.[635] On the Canadian scene, the results of the Weir Survey indicated that in the early 1930's a 20% and above rate of attrition was often found in nursing schools.[636] It is thus not surprising that between 1922 and 1951 more than 20% of the EGH students did not graduate. However, the results show that the percentage of withdrawal was particularly elevated between 1932 and 1941. It is believed that the higher percentage (28.09%) than usual may have been related to the economic depression. It has already been stated that the increased enrolment noted in the period may have been linked to economic factors. If such was the case, it is probable that some of the students who came to the school chose nursing for the "wrong reasons" or were admitted even if their chances of success were limited. In addition, a larger than usual number of students may have been negatively affected by family problems. In particular, worrying may have increased their vulnerability to disease, and decreased their ability to perform as expected which in many cases may have led to dismissal. Mussallem examined Canadian schools of nursing withdrawal statistics between 1948 and 1962. She found that 18.60% of the students enrolled during this period of time did not complete their studies.[637] For the same years, a percentage of 18.89 was found for the EGH students. It is thus evident that for those years the EGH school percentage of withdrawal was almost identical to the national norm.

The results presented in Table 69 show that based on initial enrolment a larger percentage of students withdrew during the first half of the program. Naturally, the same trends are found when percentages are based on the total number of withdrawals

---

[635] Susan Mokotoff Reverby, "The nursing disorder: a critical history of the hospital-nursing relationship 1860-1945," (Ph.D. diss., Boston University Graduate School, 1982), 104.

[636] The results of the Weir Survey are further addressed in the next section.

[637] Helen, K. Mussallem, ***Nursing education in Canada - Royal Commission on Health Services***, (Ottawa: Queen's Printer, 1965), 27.

(See Table 70). The results presented in Table 70 show that overall 81.77% of the students left during the first half of the program. It is also apparent that percentages were stable between 1922 and 1961 (ranged from 80.36% to 83.67%). Consequently the percentage of students who left during the second half of the program was also stable. Considering that it ranged between 16.13% and 18.18% between 1932 and 1961, it is likely that the 10 subjects of the 1922-1931 cohort for whom a year of withdrawal was unknown also left during the second half of the program. The situation appears somewhat different for the period of 1962 to 1965 when 77.77% of the students withdrew during the first half of their studies and 22.22% during the second half. However, the small size of this cohort and the reasons for withdrawal make it difficult to suggest that the difference was due to a change in attrition patterns. In fact the raw data revealed that two of the six students who left in the second half of the program did so because they were getting married. In the previous decade eight of the students who had left during the same portion of the program had withdrew because of marriage, and in both cohorts illness was the attributed caused of departure for two students. Marriage and illness thus explain the departure of 80% of the students from 1961 to 1965 who withdrew in the second portion of their studies, as well as the reasons for withdrawal for 62.5% of the students of the previous decade.

Causes of withdrawal

The above results show that attrition rates were fairly stable over time. However, an examination of the causes of withdrawal is necessary in order to explain the statistics and more importantly to cast some light on nursing education between 1919 and 1965. Twenty-seven reasons for withdrawal were identified in the school records. To facilitate analysis these reasons were grouped into five categories: dislike of nursing, illness, marriage, personal reasons, and not satisfactory.[638]

Since illness (including death) and marriage were self-explanatory and common causes of withdrawal, they were left as separate categories. However, a judgment call was necessary to classify the remaining 25 causes. Fourteen of these were grouped under the "not satisfactory" category: advised to leave/not suited for nursing (10)[639], dismissed (15), failure of exams (17), immature (1), incompetent (2), inefficient (4), not dependable (3), not able to adapt to discipline and rules (1), not satisfactory (26), poor clinical work (3), poor conduct (7), poor grades (24), and unprofessional (1). Seven causes were classified as "personal causes": entered convent (1), father transferred to another city (1), father's death (1), home problems (3), illness of one parent (3), leave of absence (1),[640] and personal reasons (4). Finally, four reasons were included in the "dislike nursing" category: dislike nursing (56), left to study in another field (50), not happy with nursing (2) and stayed for less than 3 weeks (2).

---

[638] Cases for whom reasons for withdrawal were unknown are also included in this analysis.

It appears from this list that the statements given to explain withdrawal were often vague. For example, "unsatisfactory" which was used 26 times can be interpreted in a number of ways. A student might have displayed unprofessional behavior, her academic or clinical performances may have been inadequate, etc... It is also possible that the true causes may have been hidden under vague terms such as illness or dislike of nursing. However, the lack of specificity should not be seen as a phenomenon unique to the EGH school of nursing. For example, Mussallem found that terms such as "dislike nursing" were often subjective evaluations made by school directors.[641] Similarly, it is unlikely that nursing schools were the only ones who submitted subjective assessments, and a degree of subjectivity should not be seen as an anomaly in itself. In particular, it must be taken into account that like students in other fields, those who chose to leave may often have provided vague reasons. In cases of dismissal, concerns for the student's future may have also justified the use of vague terms or of reasons other than the ones which at face value appeared more objective. An hypothetical scenario can illustrate how this could have happened: "The grades of student X are borderline failure. However, she has had excellent marks in the past and seems to be affected by personal problems which she does not wish to disclose. What should be stated as the cause of withdrawal?" In such a case, it may be reasonable and justifiable to state that the student left for personal reasons rather than because of a poor academic performance. Another weakness in the original data is that in most cases it was not possible to determine if the student had left of her own will or if she had been asked to leave. Because of these limitations, interpretations should be made with caution and definitive conclusions cannot be made. Nevertheless, withdrawal data is still useful because the reasons reveal aspects of the sub-culture of the school of nursing and permit comparison with statistics available for other institutions.

---

[639] The number in parenthesis indicates the number of times the reason was mentioned.

[640] Since it could not be determined if this student came back, she was included in this analysis.

[641] Helen K. Mussallem, ***Nursing education in Canada***, 28.

Unsatisfactory performance

The results presented in Table 71 and 72 provide general statistics about causes of withdrawal. It can be seen that "unsatisfactory" performance was the most frequently cited cause of departure (see Table 71) and that the percentage of students who left for that reason was quite stable during the first three periods of study. However, it was not a reason for withdrawal for any of the students who left during the last five months of the program (see percentages of Table 72). It seems reasonable that an unsatisfactory performance would have been the most common cause of withdrawal and that it remained the prime reason until the last few months of study. Based on these results, it also appears that the sisters had standards which had to be met.

In his survey, Weir used the class of 1926-1929 (of 14 hospitals with at least 100 beds) to calculate the percentage of students who left because of an unsatisfactory performance.[642] Based on total enrolment on the first day of the program, he found that 14.05% of the students left for that reason. Unfortunately, the EGH data for the class of 1926-1929 did not include reasons for withdrawal. Although the data of subsequent years included this type of information, there were often some students for whom the reason for withdrawal was not recorded. Considering this as a limitation, it was nevertheless decided to compare Weir's results with the EGH data for all students who began their studies between 1927 and 1932 (last students who enrolled before the

---

[642] George, M. Weir, ***Survey of nursing education in Canada***, (Toronto: University of Toronto Press, 1932), 184.

TABLE 71

NUMBER AND PERCENTAGE OF WITHDRAWAL BY CAUSES OF WITHDRAWAL

Cause	n (%)
Unsatisfactory performance	114 (29.69)
Illness	79 (20.57)
Dislike nursing	65 (16.93)
Marriage	41 (10.68)
Personal reason	14 (3.64)
Unknown reason	71 (18.49)
TOTAL	384 (100.00)

TABLE 72

NUMBER AND PERCENTAGE OF WITHDRAWAL BY CAUSE PER PERIOD OF STUDY

Cause	year 1 n (%)	year 1 or 2 n (%)	year 2 or 3 n (%)	year 3 n (%)	unknown year n (%)
Unsatisfactory performance	48 (27.91)	48 (33.80)	17 (33.33)		1 (8.33)
Illness	25 (14.53)	40 (28.17)	11 (21.57)	2 (28.57)	1 (8.33)
Dislike nursing	34 (19.77)	25 (17.61)	6 (11.76)		
Marriage	12 (6.98)	12 (8.45)	13 (25.49)	4 (57.14)	
Personal cause	7 (4.07)	5 (3.52)	1 (1.96)	1 (14.28)	
Unknown cause	46 (26.74)	12 (8.45)	3 (5.88)		10 (83.33)
TOTAL	172 (100.00)	142 (100.00)	51 (100.00)	7 (100.00)	12 (100.00)

publication of Weir's results). Based on "day one" enrolment of each class, 249 students enrolled at the EGH school between 1927 and 1932. Thirty-two (12.85%) left the school because of an unsatisfactory performance and in 14 cases (5.62%) the reason for departure could not be determined. Thus the percentage of withdrawal for unsatisfactory performance could have been between 12.85% and 18.47%.[643] It thus appears that the EGH statistics were comparable to those reported by Weir. This is not surprising since the EGH school seemed to be typical in most other aspects. Similarly, Mussallem, provided national statistics on reasons for withdrawal for selected classes who graduated between 1949 and 1962.[644] Again in respect of the unsatisfactory category, the EGH was within the national norms (See Table 73).

TABLE 73

PERCENTAGE OF WITHDRAWALS ATTRIBUTED TO AN UNSATISFACTORY PERFORMANCE FOR SELECTED YEARS

Graduating class	National %[645]	EGH %
1949	37.5	33.3
1951	38.7	38.8
1959	30.9	33.3
1962	41.4	42.8
Mean percentage	37.1	37.1

Illness

Illness was the second most common reason for withdrawal at the EGH school of nursing (see Table 71 and 72). Slightly more than 20% of the students who withdrew left for that reason. The results presented in Table 72 show that after the first period of study, there were always more than 20% of the students who left for this reason. Surprisingly, Weir did not report the percentage of students who withdrew because of illness. However, he discussed at length the fact that students were overworked and had health problems. He found that the norm amongst students was to feel tired most of the time and attributed this condition to the long hours work, to the absence of sick time and to the small number of hours allowed for rest and leisure. At the time of his study, Weir found that the Canadian norm (same as on the Prairies) for nursing students was a twelve hours day of work.[646] Incidently, the EGH students worked twelve hours a day in the early 1930's and it is logical to suggest that some students' health may have been affected by this strenuous schedule.

---

[643] These percentages do not reflect the results presented in Table 72 and 73 because the percentages calculated in these Tables were based on total withdrawal as opposed to total enrolment.

[644] Her statistics were based on the total number of withdrawals. Mussallem, ***Nursing education in Canada***, 29.

[645] Ibid, for national statistics.

TABLE 74

PERCENTAGE OF WITHDRAWALS ATTRIBUTED TO ILLNESS FOR SELECTED YEARS

Graduating class	National %[647]	EGH
1949	19.3	22.2
1951	20.0	16.6
1959	9.8	6.6
1962	9.5	28.5
Mean percentage	14.7	18.5

Mussallem examined the percentage of students who withdrew because of illness and her results were similar to those found in this study except for the graduating class of 1962 (see Table 74). However, it must be noted that in 1962, one of the two students who withdrew because of illness had died of cancer. In addition, between 1959 and 1965, the class of 1962 was the only one which students left for reasons of illness.

---

[646] Weir, ***Survey of nursing education***, 175-178.

[647] Mussallem, ***Nursing education in Canada***, 29.

Therefore, it can be suggested that the EGH school was not significantly different from the average Canadian school. Since the provision of sick leaves or sick days became more common in the 1950's, it seems reasonable to conclude that the percentage of withdrawals attributed to illness was lower from the late 1950's onward. The decrease in the number of hours of work which took place during these decades probably also led to lower percentages.

Types of illness

Unfortunately diagnosis was recorded for only 11 students (see Table 75) who were reported to have withdrawn because of illness. However, the recorded diagnosis were revealing. It is likely that the health problems of at least two students were related to occupational risk factors. The student who had eczema on her hands was probably sensitive to chemical products used in antiseptic cleaning solutions, while the individual who had a back injury probably hurt herself lifting or moving a patient. It could not be determined if the four students who had tuberculosis contracted the disease while they were at the EGH. However, three of them were diagnosed during their first term of their studies. It is thus likely that they would have had the disease prior to enroling at the school. In light of the number of tuberculosis beds at the hospital it is probable that the sisters paid particular attention to that disease and that these students may have been diagnosed as a result of an admission screening. Finally, the individual who died of tuberculosis was either in the first or second year of the program of study. In her case, it is more possible that she may have contracted the disease while at the EGH.

One wonders why diagnosis was not provided for 68 out of 79 students who left because of illness. It is possible that until the mid 1940s' many of them did not have a specific disease but decided or were asked to leave because they were not resilient enough to work ten to twelve hours a day almost seven days a week. In addition, it is likely that illness may have been cited as a sort of "catchall" reason for departure when in fact other reasons should have been provided. Considering the number of years during which the EGH operated a sanatorium, one wonders if some of these 68 students left because they had contracted tuberculosis. However, based on the fact that the sisters acknowledged four cases of tuberculosis, there is no reason to believe that other cases would not have been recorded in the withdrawal ledger. Four cases may seem like a small number, but it is possible that being a student in a hospital where there was a sanatorium may have reduced the risk of contracting tuberculosis rather than increased it. In 1936, the curriculum committee of the Canadian Nurses Association wrote:

> While there is some discussion as to the possible danger of exposing students to tuberculosis by including it in the curriculum, as a required clinical service, it should be pointed out that a survey of patients in any general hospital would probably disclose a fair percentage of undiagnosed tuberculosis patients. The actual danger therefore of nursing patients in a sanatorium, under well controlled conditions, would seem to be a lesser risk to the student.[648]

TABLE 75

AVAILABLE DIAGNOSIS OF STUDENTS
WHO WITHDREW BECAUSE OF ILLNESS

Diagnosis	n of students	year of withdrawal
Allergies	1	1952
Back injury	1	1949
Eczema (hands)	1	1957
Poor vision	1	1922
Tuberculosis	3	1928, 1944, 1947
Died of cancer	1	1961
Died of tuberculosis	1	1946
Died in a car accident	2	1928, 1958

Dislike nursing

Disliking nursing was the recorded reason for withdrawal for 65 (16.93%)

---

[648] Canadian Nurses Association, ***A proposed curriculum for schools of nursing in Canada***, (Montreal: author, 1936), 130.

students. This percentage is not surprising and as could have been expected that this reason would have become less frequent as students advanced in the program (see Table 72). As with other reasons for withdrawal, the percentages found at the EGH were comparable to those reported by Mussallem (see Table 76).

TABLE 76

PERCENTAGE OF WITHDRAWALS ATTRIBUTED TO A DISLIKE OF NURSING FOR SELECTED YEARS

Graduating class	National %[649]	EGH %
1949	20.4	11.1
1951	16.8	16.6
1959	19.1	20.0
1962	17.1	28.6
Mean percentage	18.4	19.1

Marriage

Marriage was the only reason for withdrawal which increased in percentage as students advanced in the program (see Table 72). This pattern can be attributed to the fact that the percentage of students who withdrew for other reasons decreased in the second half of the program. Until the 1960's, students who married had to leave the school.[650] The practice of refusing admission to married women or of letting go those who wanted to marry was the norm in Canadian schools and this continued well into the 1960's. Once again the results found at the EGH were within the national norm (see Table 77).

---

[649] Ibid.

[650] It was found in the withdrawal ledger that in 1962 a student was granted a leave of absence enabling her to get married and to be able to continue her studies.

TABLE 77

PERCENTAGE OF WITHDRAWALS ATTRIBUTED TO MARRIAGE FOR SELECTED YEARS

Graduating class	National %[651]	EGH %
1949	15.4	22.2
1951	16.0	22.2
1959	19.8	20.0
1962	18.9	14.3
Mean percentage	17.5	19.7

Personal reasons

The percentage of students who left for personal reasons was fairly stable during each period of the program of study (see Table 72). The raw data revealed that three students withdrew because of unspecified home problems, three because of the illness of one parent (in two cases the mother was ill) and one because of the death of her father. Thus, half of the students who withdrew for personal reasons had to leave because of home responsibilities. It would have been interesting to establish if a similar proportion of sons were asked to interrupt their education because of family problems. Considering the cultural norms of the time, sons may have been asked to leave school to support the family in cases where their fathers could no longer fulfil this role. However, it is unlikely that they would have been asked to leave school to take care of ill parents. It is evident that social values played an important role in this type of withdrawal, and it may be suggested that if these students had been men, many would have been able to continue their studies. Again, the EGH data was comparable to the national norm, even though there was more variability between selected years (see Table 78).

---

[651] Ibid.

TABLE 78

PERCENTAGE OF WITHDRAWALS ATTRIBUTED TO PERSONAL REASONS FOR SELECTED YEARS

Graduating class	National %[652]	EGH %
1949	3.2	0.0
1951	3.4	5.5
1959	6.1	6.7
1962	6.9	0.0
Mean percentage	4.9	3.1

Patterns of causes of withdrawal over time

The results presented in Table 79 provide the number and percentage of withdrawals by reasons for withdrawal by period of time. The large percentage (42.86%) of subjects, in the classes between 1919 and 1928, for whom the cause of withdrawal was unknown must be taken into account when examining the large differences noted between these years and those in the subsequent decade. The relatively high percentage (26.73%) of unknown reasons must also be considered when comparing the cohort of 1949 to 1958 with the preceding and following cohorts. Keeping this in mind, it is possible to suggest some trends in enrolment patterns.

The results presented in Table 79 show that illness became a less frequent cause of withdrawal as time went by. As stated earlier, it is likely that this pattern was related to the gradual decrease in the number of hours of work of nursing students and in the introduction of sick time policies. The percentage of students who left nursing because they disliked the field varied significantly over time. Interestingly, the highest percentage (37.5%) occurred between 1959 and 1965. It is difficult to propose explanations for this phenomenon. However, greater opportunities to study in other fields may have been a key factor. In previous decades, women had had fewer choices open to them. A number of students may have stayed in nursing even if they did not like the field and for the simple reason that there were few other possible fields of study. Those that were available, namely teaching and secretarial work, may have been even less appealing to them. In previous years, changing one's mind about a career choice may also have been less socially acceptable than in later years. The number and percentage of students who left because of a not satisfactory performance also varied over time (see Table 79). Again it is difficult to explain these variations. However, the high percentage found in the period between 1929 and 1938 may have been linked to the economic depression.[653] It may also have been the case that the directors of that era were less flexible than those who were in charge in later years.

---

[652] Mussallem, ***Nursing education in Canada***, 29.

TABLE 79

NUMBER AND PERCENTAGE OF WITHDRAWALS BY CAUSE OF WITHDRAWAL BY TIME PERIOD

Cause	1919-1928 n (%)	1929-1938 n (%)	1939-1948 n (%)	1949-1958 n (%)	1959-1965 n (%)
Unsatisfactory performance	8 (19.05)	44 (43.14)	36 (33.64)	18 (17.82)	8 (25.00)
Illness	13 (42.86)	30 (29.41)	22 (20.56)	12 (11.88)	2 (6.25)
Dislike nursing	3 (7.14)	12 (11.76)	24 (22.43)	14 (13.86)	12 (37.50)
Marriage		2 (1.96)	7 (6.54)	25 (24.75)	7 (21.87)
Personal cause		2 (1.96)	5 (4.95)	5 (4.95)	3 (9.37)
Unknown cause	18 (42.86)	12 (11.76)	14 (13.08)	27 (26.73)	
TOTAL	42 (100.00)	102 (100.00)	107 (100.00)	101 (100.00)	32 (100.00)

Considering the large number of reasons which were included in the unsatisfactory category, the raw data was examined in order to see if sub-patterns could be found. The results presented in Table 80 provide the number and percentage of withdrawals for all reasons included in this category over time. It is apparent that after 1948 more specific reasons were provided since the general "unsatisfactory" was no longer used as a cause. The lack of specificity prior to that date must be considered when interpreting the results. It must also be noted that the sample sizes of the periods of 1919-1928 and 1959-1965 were smaller than during the intermediate years, which again must be considered when analyzing the data.

---

[653] This hypothesis was discussed previously.

TABLE 80

NUMBER AND PERCENTAGE OF WITHDRAWAL BY UNSATISFACTORY CAUSES BY TIME PERIOD

Cause	1919-1928 n (%)	1929-1938 n (%)	1939-1948 n (%)	1949-1958 n (%)	1959-1965 n (%)
Unsatisfactory Performance	7 (87.5)	15 (34.09)	4 (11.11)		
Poor grades		1 (2.27)	12 (33.33)	6 (33.33)	5 (62.50)
Exam failure		3 (6.82)	6 (16.67)	7 (38.89)	1 (12.50)
Dismissed		12 (27.27)	2 (5.55)	1 (5.55)	
Not suited for nursing, advised to leave			9 (25.00)	1 (5.55)	
Poor conduct	1 (12.5)	4 (9.09)	1 (2.78)		1 (12.50)
Not efficient		1 (2.27)	1 (2.78)	2 (11.11)	
Not dependable		2 (4.54)		1 (5.55)	
Poor clinical		2 (4.54)			1 (12.50)
Incompetent		2 (4.54)			
Immature			1 (2.78)		
Not able to adapt to rules		1 (2.27)			
Unprofessional		1 (2.27)			
TOTAL	8 (100.00)	44 (100.00)	36 (100.00)	18 (100.00)	8 (100.00)

The data presented in Table 80 suggest that academic performance probably assumed greater importance over time. Adding the percentages of the "poor grades" and "failure of exams" categories, it can be seen that poor academic performance was the cause of withdrawal for 9.09% of those who left for not satisfactory performance between 1929 and 1938, 50% between 1939 and 1948, 72.22% between 1949 and 1958 and 75% between 1959 and 1965. It must be noted that the number of cases for whom poor academic performance was reported between 1929 and 1938 may poorly reflect the reality since in 34.07% of the cases in this cohort the vague statement "not satisfactory" was utilized. Yet, even if all these students had withdrawn because of poor academic performance, the resulting percentage would still have been much lower than in the next period of time.

It is very likely that the increase in percentage of withdrawal for poor academic performance reflected a greater concern for this matter. Since the percentage of students who left for that reason greatly increased after 1939, it may be proposed that the increase may have been related to the recommendations of Weir, including those concerning the need for improvement in nursing education and student evaluation. During the following decades curriculum development and improving nursing education became key issues for the Canadian Nurses Association. In particular, the curriculum committee of the association considered that it was urgent to integrate the clinical and theoretical components of nursing education "... theory and practice are not independent and distinct entities, but are interdependent and organically related."[654] It is believed that the Grey Nuns wanted to improve the integration of theory and practice and this may explain why the percentage of withdrawals related to poor academic performance increased over time.

Withdrawals for poor conduct and dismissals (probably another term used for unacceptable behaviors) were more common before 1939. It is probable that many of the behaviors which lead to expulsion in the 1920's would not have had the same consequences in later years. In the early 1930's Weir noted that schools' regulations were often too strict and that at times the social life of students was unduly restricted.[655] In society and schools in general there is no doubt that disciplinary measures became more lenient after World War II. It is thus not surprising that similar changes would have taken place in schools of nursing.[656]

---

[654] Canadian Nurses Association, ***A proposed curriculum***, 48.

The percentage of students who left the school because of marriage constantly increased until 1958. The fact that the highest percentage (24.75%) was found in the period of 1949 to 1958 must be largely related to the postwar marriage rates. It must be noted that it was also during these years that shortages of nurses became a national concern. Considering that at the EGH almost a quarter of the students who withdrew left because of marriage, it is reasonable to suggest that the regulations concerning married women directly and significantly contributed to the shortage of nurses. Finally, the percentage of students who left for personal reasons was always so small that it is almost impossible to verify if patterns of change could be seen over time.

Relationship between times of withdrawal, periods of time and causes of withdrawal

The purpose of this analysis was to determine if there were variations over time in terms of when students left the program. Comparisons were calculated for four of the reasons for withdrawal.[657] The results showed that for illness, unsatisfactory and dislike of nursing categories, the percentages of students who withdrew in the first and second half of the program did not vary significantly overtime. These results further confirm that there was a relationship between attrition and the duration of time in the program. In other words, succeeding in the first half of the program increased the likelihood of success in the second half. Understandably, the same could not be said about the students who withdrew because of marriage. The results presented in Table 81 show that the percentage greatly varied over time and that the total number of students who left for that reason in each half of the program was not significantly different.

---

[655] Weir, ***A survey of nursing education***, 197.

[656] The restrictions imposed on students' off duty time are discussed further in the next section.

[657] The sample size for the category "personal reasons" was too small to permit comparisons over time.

TABLE 81

NUMBER AND PERCENTAGE OF WITHDRAWALS BECAUSE OF MARRIAGE IN EACH HALF OF THE PROGRAM BY TIME PERIOD

Period of time	First half n (%)	Second half n (%)
1929-1938	2 (100.0)	
1939-1948	3 (42.8)	4 (57.2)
1949-1958	14 (56.0)	11 (44.0)
1959-1965	5 (71.4)	2 (28.6)
Total	24 (58.5)	17 (41.5)

The education and life of nursing students

The purpose of this section is to examine the education and life of the students of the EGH school of nursing. Schedules of work and leisure, curriculum, leisure activities, the transmission of Catholic values and the faculty are of all of interest since the data pertaining to these topics provided valuable information which could be used to understand the evolution of the school and further assess the extent to which it resembled other Canadian schools. Chronicles were written for the school of nursing, just as they were for the hospital. Although fairly informative, they were certainly less voluminous than the chronicles of the hospital.[658] This is not surprising since the school was a much smaller entity. It was also noted that the hospital chronicles contained a fair amount of information about the school and at that time this information was not found in the school chronicles.[659] In general, it can be said that much more was kept about the hospital than about the school.[660] However, the Grey Nuns' archives contained other documents which were of great value in respect of the sisters' views on education and about curriculum changes over time. In order to facilitate organization, work schedules are first examined, while the remaining topics are examined within three periods of time: 1909-1942, 1943-1967, and 1968-1972.[661]

---

[658] There were approximately 200 pages of school chronicles (entitled *Histoire de l'école*) while the hospital chronicles included more than 1,000 pages.

[659] The school chronicles also contained information written at later dates. In other words some of the entries were not contemporaneous to the event.

Schedules of work and leisure

As stated earlier, one of the most important motives behind the establishment of the school of nursing in 1908 was that a school was seen as a means of providing the necessary nursing workforce to ensure the functioning of the hospital. It is thus evident that from inception, nursing education and nursing care delivery were intricately bound together. At the time, this system of education/apprenticeship was the norm in North America and nursing leaders were already well aware of its main weaknesses. A year prior to the opening of the EGH school, Nutting and Dock wrote: "The progress of nursing education on efficient lines, has been retarded by the fact that training schools are not controlled by educationalists, but by the committees of management of the hospitals ... who are primarily elected to maintain the hospital."[662] Similarly, Isabel Adams Hampton had written in 1905 that:

> The superintendent of a training school is under a threefold obligation: first, to the hospital in which she works; secondly, to the patients who are entrusted to her care; and thirdly, to the women for whose education as nurses she is responsible. The hospital and patients should always be first considered, but not to the

---

[660] It is difficult to explain why this was the case, especially since for some of the other Grey Nuns' schools of nursing much more data is available at the Grey Nuns Archives.

[661] A close examination of the data suggested that these three periods of time corresponded to a new era in the life of the school of nursing. This will be addressed while examining the various topics.

[662] Adelaide Nutting and Lavinia Dock, ***A history of nursing***, vol. 3, (New York: Putnam's Sons, 1907), 8.

exclusion of what is just and right toward the pupil nurses.[663]

The EGH school of nursing was a product of its time and during most of its history the director of the school was also the hospital director of nursing. Like the funambulist she walked on a tight rope. Her balancing act consisted in maintaining the equilibrium between two opposing forces: the needs of the nursing student and the needs of the hospital. The work schedule of the students can be seen as an indicator of the difficulty of maintaining this balance. For this indicator it is evident that most of the time the service needs of the hospital outweighed the students' educational needs.

TABLE 82

NURSING STUDENTS WORK SCHEDULES OVER TIME[664]

Period of time	n of hours per week	n of days per week
1908-1936	78	6.5
1937-1944	60	6.0
1945-1946	48 if on day shift 56 if on night shift	6.0
1947-1960	48	6.0
1961- ?	40	5.0

Results presented in Tables 82 and 83 provide descriptive data about the number of hours/days of work, leisure and holidays over time. It is important to understand that hours of work included clinical practice, lectures and time allowed for studying. The results show that between 1908 and 1936 nursing students worked 78 hours per week and had between 3 and 9 hours of entirely free time per week. Significantly, the variation in the amount of free time did not mean a corresponding reduction in the number of hours of work. It only meant that instead of being permitted to leave the hospital grounds for three hours (from two to five PM) on Sunday afternoon, they were allowed to also spend the Sunday evening away from the hospital (free from noon until 9 PM). The raw data indicated that by 1916, students were granted one late night a month (free until 11 PM). Results in Table 83 show that students had no holidays until 1922. It was only then that for the first time students had two weeks off in the summer and three days of holiday either around Christmas or the New Year holiday. The next change occurred in 1935 when summer vacations were increased to three weeks a year.

---

[663] Isabel Adams Hampton, ***Nursing: its principles and practice***, (Cleveland: E.C. Koeckert Publisher, 1905), 17-18.

[664] ASGME, EGH, Histoire de l'école (EGHS), 1908-1961.

TABLE 83

NURSING STUDENTS' LEISURE TIME AND HOLIDAYS OVER TIME[665]

Period of time	Free hours per week	Summer holidays	Christmas season
1908-1915	3 (0.5 day)	none	none
1916-1921	9 (0.5 day)*	none	none
1922-1934	9 (0.5 day)	2 weeks	3 days
1935-1936	no change	3 weeks	no change
1937-1954	12 (1 day)	no change	no change
1955-1959	no change	4 weeks	no change
1960	no change	no change	5 days
1961-1966	18 (2 days)	no change	5 or 7 days ***
1967- ?	no change	3 weeks **	?

* In 1916, the students were allowed to stay away from hospital grounds for more hours. However, this change did not decrease the number of consecutive days off (they still only had half a day of rest). ** Until 1967 the students had four weeks of summer vacations. However, one of these weeks was *in lieu* of statutory holidays. Starting in 1967, the statutory holidays began to be taken as they arose, which resulted in the loss of one week of summer vacation. However, because of the number of statutory holidays the students gained in fact three days off. *** The first year students were the only ones who were given seven days, all others had only five days.

Considering this grueling schedule, it is not amazing that a large number of students became ill and or decided to leave the school because they found this life regimen too difficult. According to Mrs McCool, a graduate of 1911, it also happened that students had to work more than twelve hours a day; "... if there were many to care for, and the willing hands were too few, it was the accepted rule that we remained at the bedside of the sick until midnight, or the next morning, if necessary."[666] The account of a graduate of 1932 supports the evidence found in the school chronicles:

---

[665] ASGME, EGHS, 1908-1967.

> ... the day shift was from 7 a.m. to 7 p.m. and the night shift was the same hours and vice versa. We had one half day a week; we were to be in, I believe, by 9.30 p.m. and in bed by 10 p.m. Then Sister Chauvin came around doing her night check; the jingling of her keys forewarned us of her coming. This likely was on purpose as she was strict, but she was also fair.[667]

The same graduate also revealed that when they took care of isolation cases they were on duty for twenty four hours.[668]

In the early 1930's (and later), a twelve hour day of work was the norm in Canadian nursing schools.[669] Understandably, Weir found this type of schedule to be detrimental to the students' well-being. He recommended that students should not work more than eight hours a day and he judiciously made the point that patients would also benefit from this change since the students would be more "alert and physically vigourous".[670] The EGH data shows that eight hour days were introduced only in 1947 and that at that time students still worked six days a week. In fact, it was only in 1961, that a five-day a week (40 hours) schedule was adopted. According to the school records the EGH was the first hospital of the province which gave two full days of rest to its nursing students.[671] Nonetheless, it seems that the Weir report may have had an effect on the number of hours of work since in 1937 the work week was reduced to 60 hours and students were given a full day off.

---

[666] ASGME, EGHS, letter of Mrs McCool, graduate of 1991, not dated.

[667] Gahagan, *Yes father*, 65.

[668] Ibid., 71.

[669] Weir, *Survey of nursing education*, 176.

[670] Ibid., 197.

Noticeably, it was after this schedule change that the number of registered nurses began to significantly increase. In 1936, there were 10 nurses, 24 by 1937 and 36 by 1940.[672] This gives further support to the notion that students were part of the work force and that their schedule was primarily designed to meet hospital needs. This is again evident when examining the data of subsequent years. Results presented in Table 82 show that in 1945 the students' hours of work were reduced to 48 hours per week, but only for the day shift. The fact that it took another year to have the same number of hours of work for the night shift suggests that the hospital had heavily relied on the students to ensure night coverage. In 1959, Mussallem found that hospitals still heavily depended on the nursing students workforce at night. In concrete terms, this meant that students often worked more nights than registered nurses and that in many cases they were delegated responsibilities beyond their levels of expertise.[673] In addition, students had to work on statutory holidays until 1967. Again, this shows that the hospital used them to meet staffing needs. Similarly nursing students were not provided with sick days until 1951 when they were granted two weeks a year.[674] It seems that the EGH school was within the norms since Mussallem found that in 1959, 96% of the schools had sick time allowances varying between seven and 14 days a year.[675]

Information about other local schools of nursing shows that over time the work schedules of their students were comparable to the EGH students' schedule.[676] In 1909, the RAH students worked 79 hours a week and had five hours off on Sunday.[677] Similarly, in 1918 and 1923 the students of the Strathcona Hospital School (became University of Alberta School in 1923) had an identical schedule to that of the EGH school.[678] In 1935, and apparently in response to the Weir survey, the hours of work of the RAH students were decreased to 52 (per week).[679] The same schedule was also adopted by the UAH in 1936.[680] It is thus evident that in 1936, the EGH students worked eight hours more per week than their colleagues of the RAH and UAH. However, additional information about the RAH shows that the 52 hours were distributed over seven days (five days of eight hours and two days of six hours). Therefore the RAH students worked seven days a week while the EGH students had an entire day off.[681] It is thus difficult to conclude that the RAH students had a more favourable schedule than the EGH students. Interestingly, in 1947, two hours of work were added to the schedule of the RAH students (a 54 hours work week was established). Under their new schedules the students worked nine hours a day, six days a week, and had a day of rest on Sunday.[682] It thus appears that at that time, the EGH students had a lighter schedule since they worked 48 hours distributed over six days. Finally, the RAH school adopted a 40 hour schedule in 1962, one year after the EGH school.[683]

---

[671] ASGME, EGHS, January 1961.

[672] ASGME, EGH, Annual reports, 1936, 1937 and 1940.

[673] Helen K. Mussallem, ***Spotlight on nursing education: the report of a pilot project for the evaluation of schools of nursing in Canada***, (Ottawa: Canadian Nurses Association, 1960), 74-75.

[674] ASGME, EGHS, 1951. Sick time increased to three weeks in 1955.

[675] Mussallem, ***Spotlight***, 53.

---

[676] This information was obtained using published histories of the RAH and UAH schools of nursing. It must be noted that although the authors of the two books did not precisely report their sources of reference, introductory statements indicated that they relied on archival material and graduates' reminiscences. Similar information was not available for the Misericordia Hospital School of Nursing.

[677] Dorward and Tookey, ***Below the flight path***, 5.

[678] Betty Wilson, ***To teach this art. The history of the schools of nursing at the University of Alberta 1924-1974***, (Edmonton: Hallamshire Publishers, 1977), 9 and 28.

[679] The authors stated that the change was made in response to recommendations of the Canadian Nurses Association. Dorward and Tookey, ***Below the flight path***, 35.

[680] Wilson, ***To teach this art***, 64.

[681] Dorward and Tookey, ***Below the flight path***, 59.

[682] Ibid.

Monetary allowance

One of the characteristics of schools of nursing was that students were often provided with a monthly allowance which was seen as a form of salary for the work they accomplished in the hospital. At the EGH, this practice began only in 1943, while at the RAH evidence shows that it existed before 1935. However, the first students of the UAH (1923) had such stipend.[684] It is difficult to explain why the EGH students did not receive a stipend as early as the students of the RAH and UAH. The better financial situation of these two hospitals may have contributed to the difference. It is also possible that institutional values may have come into play. The Grey Nuns may have considered that the introduction of a financial reward may have made more difficult the transmission of charitable values. It would have been interesting to have data about the other Catholic school of the city, since it may have lend support to this hypothesis.

Once introduced, the EGH allowances were comparable to those of the RAH. In 1935, the RAH students received between $4.50 and $10.00 a month[685], while in 1943, the EGH students received between $5.00 and $10.00 a month.[686] Data for subsequent years was not available, but it is suspected that the practice must have still existed in the 1950's since in 1959 Mussallem noted that 84% of the schools included in her survey still provided a stipend and the EGH school was comparable to the schools included in her study.[687]

---

[683] Ibid., 84. The schedule of the UAH students was not available for these years.

[684] Allowances existed at the RAH prior to 1935. It was in that year that this came to light, as there are recorded indications that financial difficulties pushed the school to reduce the monthly amount. Dorward and Tookey, ***Below the flight path***, 33; Wilson, ***To teach this art***, 10.

[685] Dorward and Tookey, ***Below the flight path***, 33.

[686] ASGME, EGHS, 1943.

[687] Mussallem, ***Spotlight***, 55.

Education and life from 1908 until 1942

Curriculum and instruction

As already discussed, the students of that era worked long hours, the majority of which were spent in the clinical field. The raw data indicated that most of the classroom teaching took place in the evening after a full day of work on nursing units.[688] This type of scheduling of the theoretical component of nursing education programs was also in used at the RAH and UAH and was the norm in Canadian schools.[689] In 1932, the results of the Weir survey showed that students were too tired most of the time to benefit from evening lectures. During his investigation, Weir, recorded observations about students' behaviors at evening lectures. He wrote: "A few who have been long hours on ward duty, yield to the weariness of fatigue: first a condition of passive attention, then the glassy stare of mental torpor, reaching its culmination when Morpheus claims the victim!"[690] He also noted that physicians' lectures were rarely adapted to nursing students' needs and that many were slightly modified medical speeches.[691] These types of situations probably existed at the EGH where all lectures given by physicians were taught in the evening.[692]

The precise curricula taught at the EGH were not available for the period under study. However, it was found that, in 1908, students received instruction in nursing arts (taught by the school director) and in nursing science (taught by physicians). Nursing science consisted of five subjects: anatomy, physiology, medicine, surgery and obstetrics.[693] In 1916, gynecology/obstetric and pediatric nursing were added to the science content and more importantly, obstetrical nursing lectures began to be taught by the school director.[694] Another important change took place in 1917 when the program was extended to 36 months (30 months prior to that time). These six additional months were added to meet the requirements of the Canadian Army Medical Corps. Two new topics were introduced: chemistry and dietetics.[695] These changes were maintained after the end of WWI and the length of the program continued to be 36 months until 1968. In 1935, tuberculosis care became a full component of the curriculum and it is likely that the introduction of the subject was planned as an important part of the opening of the sanatorium department. It may also have been in response to recommendations made by Weir, since he proposed that this specialty should be introduced in a school's curriculum.[696]

---

[688] ASGME, EGHS, 1908 to 1942.

[689] Dorward and Tookey, ***Below the flight path***, 52; Wilson, ***To teach this art***, 28.

[690] Weir, ***Survey of nursing education***, 329.

[691] Ibid., 377.

[692] ASGME, EGHS, 1908.

[693] The topics of nursing art were not recorded. ASGME, EGHS, 1908.

It is evident form the available data that the curricula of the era were patterned on the medical model and that "scientific content" was primarily taught by physicians. However, by the end of this era, nursing science and nursing arts instructors were hired.[697] The increasing number of students probably justified the addition of these two nurses to the school staff, as it would have been difficult for the director to continue to operate the school alone. It is also believed that this addition of personnel reflected new trends in nursing and was among the steps which led to the next era of nursing education. However, it must be understood that the fact that physicians gave a large proportion of the lectures did not mean that the sisters were not truly involved in the education of the nursing students. As in other schools most of the learning took place on nursing units where the students were under the supervision of head nurses (hospitallers in this case).

There are in fact indications that the Grey Nuns had a clear vision of nursing education. On 14 September 1916, Mother Piché (Superior General) visited the EGH and expressed the wish that the Grey Nuns of all western Canadian schools of nursing of the Order organize a series of nursing conferences. This practice had just been established in Montreal and she believed that exchange of ideas and of experience could contribute to enhance the positive aspects of the patterns of education and care delivery in all Grey Nuns' schools of nursing. It is not known how many meetings occurred in Western Canada. However, a three day meeting was held at the EGH in 1917.[698] Twenty-nine sisters participated in the event and all the papers were reproduced in typed proceedings. Ten papers were presented[699]: Our hospitals, Our nurses, Our laboratory and X Ray departments, Our pharmacies, Our patient units, Our maternity units, Our emergency kitchens, Our operating rooms, Suggestions for theoretical teaching, and Our duties. Discussion time was also included in the conference schedule and it is known that some of the conclusions reached at these sessions were forwarded to the Motherhouse. Nursing education was addressed in most papers and the Proceedings provide an excellent source of information about the views of the sisters on it.

---

[694] ASGME, EGHS, 1916.

[695] ASGME, EGHS, 1917; Ell, "Edmonton General," 32.

[696] The other subjects recommended by the surveyor (medicine, surgery, maternity, pediatrics and dietetics) were all part of the EGH curriculum at the time. Weir, 279.

[697] ASGME, EGHS, 1937 and 1939.

Sister Duckett, the Superior of the Holy Cross Hospital (she had previously worked at the EGH), presented the paper on Grey Nuns' hospitals. She emphasized the importance of nursing registration and that hospitallers had to be educators to the same extent as the sisters who taught school children or were involved in home economics programs.[700] For her, the hospitaller had to be well organized and able to transmit an approach to care which would be applicable to other institutions or to private duty service.[701] It is evident that she considered that the director of the school was critical to the success of nursing education. "Il faut à la directrice des gardes beaucoup d'expérience dans le soin des malades parce que l'on enseigne bien que ce que l'on possède [...] Il faut que la soeur appelée à former les jeunes personnes pour la noble profession de garde-malade ait donné ses preuves."[702] Sister Duckett also believed that it was essential that directors of schools of nursing collaborate with hospitallers in designing new methods of caregiving. She stated that she believed that this role was very demanding and that consequently school directors should not be required to fulfil additional roles.[703]

---

[698] ASGME, EGH, School of Nursing file, compiled by Sister Jean, ***Première réunion des soeurs missionnaires dans nos hôpitaux de l'ouest, compte rendu des réunions de juillet 1917***, (Edmonton: EGH, 1917).

[699] These titles have been translated from French to English.

[700] ASGME, EGH, School of Nursing file, Sister Duckett, "Nos hôpitaux," ***Première réunion***, 15.

[701] Ibid., 21.

Another sister from Calgary, Sister Weekes, presented a paper about the education of nursing students which appeared to be based on the Holy Cross School curriculum, likely quite similar to that of the EGH. Her description was very similar to the account given by Alvine Cyr Gahagan who graduated from the EGH school in 1932.[704] Sister Weekes believed that during the probationary period, students should receive nursing instruction in the following topics: nursing ethics and hospital etiquette, bed making, nursing principles, hygiene and materia medica. Introduction to chemistry and physiology were also considered appropriate content for beginning students. According to the information provided by Sister Weekes, most of the probationary clinical experiences were directly related to patient care.[705] During the late 1920's, in most Canadian schools much of the probationary time was spent doing housemaid work.[706] However, this does not seem to have been the case at the Holy Cross Hospital and the EGH. Sister Weekes wrote that students spent some time preparing bandages and dressing supplies, but that most of their time was spent bathing patients, giving massages and alcohol rubs, applying poultices and moist dressings, feeding patients and spending some time in the diet kitchen to begin to learn about dietetic principles.[707] Gahagan gave the following description of her probationary days:

---

[702] Quote translation: The director of nurses must have broad experience in the care of patient because we teach well only what we know well. The sister who is selected to teach young persons the noble profession of nursing must be well versed in nursing care and have demonstrated her abilities. Ibid., 27.

[703] Ibid, 31.

[704] Gahagan, ***Yes father***, 63-75.

[705] ASGME, EGH, School of Nursing file, Sister Weekes, "Nos gardes-malades," ***Première réunion***, 61.

[706] Weir, ***Survey of nursing education***, 191.

> There was the learning of bathing patients, then changing the bed linens while the patient was still in bed, if need be. The rubbing of backs, which we did two to three times a day, depending on the condition of the patient. We also helped with carrying food trays to the patients, and helped the ones who needed assistance. Then there were the different enemas, and catheterizing. There also was temperature taking and charting. We would take care of these same patients for the twelve hours.[708]

Sister Weekes believed that during the junior years (1 and 2), students had to learn the disease process and be provided with clinical opportunities to observe symptoms and note the results of different treatments. Charting skills had to be learned at that stage and she stated that: "It was better to err by writing too much than too little." Students also learned to give medications and night duty was introduced during the second year. Finally, third year students were provided with experiences in the operating room and dressing rooms. The instruction of that year also included more advanced information on child care and infectious diseases.[709] It is believed that offering these courses at the end of the program was probably an efficient way to prepare graduates for their roles as independent nurses employed by families in the community. Again the sequence of learning was similar to the experience described by Gahagan.[710]

---

[707] ASGME, EGH, School of Nursing file, Sister Weekes, "Nos gardes-malades," ***Première réunion***, 61.

[708] Gahagan, ***Yes father***, 65.

[709] ASGME, EGH, School of Nursing file, Sister Weekes, ***Première réunion***, 66-72.

[710] Gahagan, ***Yes father***, 66-72.

Importantly, Sister Weekes recommended that nursing students should be encouraged to purchase nursing journals and to seek affiliation with nursing associations since it "... helped to broaden their views and ideas."[711]

Sister Sainte-Praxède, of Saskatoon presented a paper about patient wards and indicated that it was important that hospitallers take students on rounds and give them bedside instructions in order for them to learn treatments and symptoms of disease. She also stated that nursing students should treat their patients from "beginning to end" in order to learn the evolution of disease.[712] The views of Sister Sainte-Praxède suggested that learning took place using the total patient care assignment method. It is likely that this method was also in use at the EGH and the Proceedings of the conference indicate that the sisters resolved to continue to use this patient assignment method. They further stated that the number of patients assigned to each student should be based on her level of expertise and experience. The sisters also stated that they believed that the method of task assignments (called the efficiency method by the Canadian Nurses Association) constituted unsound practice. Gahagan's description of her experience indicates that the assignment method continued to be used at the EGH in the 1930's.[713]

It is important to recall that during the 1920's the "efficiency method" began to be increasingly used, and that in the 1930's some Canadian schools had decided to adopt it instead of the total patient care assignment system. In 1940, the Canadian Nurses Association (CNA) took position in favour of the latter method of patient assignment. The CNA believed that, through the use of this method, students learned to see nursing as a "problem solving process", and that they learned to consider "all the needs" of the patient, to see him as a "whole" person. Students, further, were provided with more learning opportunities.[714] The CNA's curriculum committee wrote:

---

[711] ASGME, EGH, School of Nursing file, Sister Weekes, "Nos gardes-malades," ***Première réunion***, 69.

[712] ASGME, EGH, School of Nursing file, Sister Sainte-Praxède, "Nos salles de patients," ***Première réunion***, 35-36.

[713] Gahagan, ***Yes father***, 66-68.

> The patient assignment method has been recommended because of the opportunities it affords to view the patient as a whole, and to determine nursing needs on the basis of an understanding of his social problems, and a knowledge of home conditions. It has been suggested also, that in planning nursing care, hygienic aspects should be kept before the student in order that she may think in terms of health nursing as well as sick nursing. With attention on health as the ultimate aim of nursing care she is likely to be more aware of teaching responsibilities. She should be encouraged to develop the ability to give instructions of the right kind on appropriate occasions and at a time when it is likely to appeal most strongly to the patient.[715]

Of interest was the notation by Petitat that the "efficiency method" was introduced at the Montreal General Hospital in the 1940's, but that it was never adopted at Notre-Dame (a Grey Nuns' hospital) or at the Hôtel-Dieu (Hospitallers of St. Joseph). Petitat put forward the belief that the "efficiency method" was contrary to the philosophy of nursing espoused by religious orders. He wrote: "... la taylorisation des soins a soulevé peu d'enthousiasme du côté francophone. Les communautés religieuses, avec leur idéologie holiste se sont d'instinct méfiées de ce modèle qui sentait un peu trop les usines automobiles de l'oncle Sam."[716] Thus the French Catholic nature of the EGH probably explains why the efficiency method was never introduced at the EGH, and that, just as at Notre-Dame, only dressing changes and medication administration were assigned to one individual.

The papers presented by Sister Saint-Augustin (Provincial Superior of St. Albert) and Sister Fafard from the EGH showed that the Grey Nuns believed that an holistic approached was indeed favoured in the teaching of nursing students. For Sister Saint-Augustin the school had to transform young women into responsible adults. The sisters had to be role models and treat the students in a "soft and fair manner". She particularly insisted on the fact that students came to the hospital to learn to become nurses and thus errors had to be expected from these learners. It followed that reprimands had to be made in a calm and humane manner. Importantly, she stated that congratulations also had to be given when students showed improvement.[717]

---

[714] Canadian Nurses Association, ***A supplement to a proposed curriculum for schools of nursing in Canada***, (Montreal: CNA, 1940), 49-52.

[715] Ibid., 96.

[716] Quote translation: "... these new methods of nursing care brought little enthusiasm in the French speaking hospitals. Religious orders, with their holistic philosophy, were instinctively suspicious of this model which was too similar to the one used in the assembly line car factories of Uncle Sam." Petitat, ***Les infirmières***, 156.

Accordingly, Sister Fafard believed that probationers should not be expected "... to provide the same kind of work, to show the same qualifications exacted from a junior nurse, a junior nurse is neither called to surpass a senior student."[718] She stated that the sisters had to be especially patient with beginners and that it was important to foster their spirit of enquiry. She wrote:

> The young woman coming in training feels that there is an enormous field open to investigations and if she is the real nurse she will be very inquisitive especially in the beginning. That tendency should be cultivated, and regulated. To the frequent inquiries, the sister "head nurse" should give a short explanation, refer the nurse to her textbooks and make her understand to be patient with herself, that it is impossible to learn the shows [sic] and things that make up nursing in a little while.[719]

A firmly held belief was that theory and practice had to go hand in hand. Sister Fafard believed that it was only through the combined effort of the teacher and the hospitaller that students could learn to nurse. She further believed that it was the teacher's duty to ask and provoke questions. She even suggested that physicians who taught for the schools should be given the nursing textbooks in order to adapt their lectures to the students' needs.[720] For Sister Fafard, contributing to the development of the pupil's spirit of inquiry seemed to be a priority. Related to this, she stated:

---

[717] ASGME, EGH, School of Nursing file, Sister Saint-Augustin, "Nos devoirs," ***Premières réunions***, 184-185.

[718] ASGME, EGH, School of Nursing file, "Suggestions pour l'enseignement théorique," ***Première réunion***, 169.

[719] Ibid.

> a good teacher should never allow a nurse to laugh at a blunder or at an incorrect answer made by a companion. If charity is to be one of the virtues of the nurse towards her patients, a schoolmate, who should be dearer to her than a stranger met in the hospital ward, deserves the same consideration. Besides being uncharitable, this kind of behavior shows a lack of education.[721]

In summary, it is evident that as early as 1918, the Grey Nuns had a vision of nursing education. They considered practice and theory to be related; they believed in a holistic approach; they acknowledged that nursing students were learners who needed to develop their spirit of enquiry and they believed that it was advisable to promote the use of scientific principles (reference to nursing texts and to nursing journals). In fact, based on the Proceedings of this conference, it may be suggested that the sisters subscribed to many of the teaching principles later proposed by the CNA in its curriculum guides of 1936 and 1940.[722] However, one has to wonder the extent to which the heavy work schedule of the students interfered with the implementation of this vision. Nonetheless, it was the case that the sisters were obviously concerned about providing a good education for their students. The use of affiliations for obstetrical nursing, during the first years of operation of the EGH sanatorium, further supports the view that they wished to provide a complete nursing education.[723]

---

[720] Ibid., 173.

[721] Free translation. Ibid., 179.

[722] Canadian Nurses Association, ***A proposed curriculum***; Canadian Nurses Association, ***A supplement***.

[723] From 1937 until 1940 the EGH students received the obstetrical experience in their program at the Misericordia Hospital in Edmonton and at the Holy Cross Hospital in Calgary.

Leisure activities

Little data were found about the leisure activities of the students prior to the 1920's. This is not surprising considering that the number of hours of work did not leave much time for recreation. In 1921, a group of graduates began to organize a school alumnae association. Monthly meetings began to be held on a regular basis, and in 1928 a formal association was created. Significantly, nurses who worked at the EGH and had graduated from other Grey Nuns' hospitals were permitted to become members. Until 1949, the alumnae had a broad mandate which included fund raising activities for the school and the hospital. That year, the ladies auxiliary was reorganized and the alumnae decided to exclusively devote its efforts to the school of nursing.[724] It was noted that it was in 1921 that the chronicles of the hospital first included statements about organized activities for nursing students. It is thus likely that these activities may have been organized by the developing alumnae. In addition, the first year book was printed in 1929, a year after the formal creation of the alumnae.[725]

The first recorded activity took place in September 1921, when a magic lantern show was presented in the study room for all students and staff who wished to be present.[726] In subsequent years, social evenings and movie presentations began to be organized on a sporadic basis.[727] Based on available records, the frequency of activities increased in the early 1930's and there is evidence that graduating classes began to take leadership in the planning of social events. For example, in 1933 they sponsored a benefit tea and donated the profits towards the purchase of new furniture for the students' library.[728] It could not be determined if the students had an association at the time, but the organization of teas, social evenings, and other events suggests that a student council may have been in place during these years. Importantly, the chronicles revealed that during the 1930's the students and sisters were increasingly coming together for social activities. In particular, it seems that the sisters started to rent movies more frequently and that often nursing students were among the viewers.[729] It also appears that during the same decade Christmas activities became more formal, gift exchanges took place every year and the tradition of a students' annual concert was established.[730] This proliferation of organized events makes one wonder if the economic crisis had to some extent created a new solidarity resulting in social activities of this nature. A tennis court was constructed in 1933, the year after Weir had suggested that students should be provided with more recreational facilities.[731]

---

[724] ASGME, EGHS, 1921-1949. Of interest the RAH alumnae was created in 1925. Dorward and Tookey, ***Below the flight path***, 118.

[725] ASGME, EGHS, 1929.

[726] ASGME, EGH, Chroniques, 21 September 1921.

[727] Ibid., 1921 to 1930.

[728] Ibid., 4 January 1933.

Graduation

Graduation was always a big event for the students of the EGH. However, it appears again that the celebrations surrounding graduation became more elaborate in the late 1930's. For the first time, in 1933, the alumnae offered a prize for the graduate who had the best overall grades. It was also during that decade that the physicians initiated the tradition of providing three prizes; general proficiency, patient care, and surgery.[732] The graduation activities of the 1930's began with a morning mass followed by a banquet in the hospital cafeteria, and an evening graduation ceremony which took place at the University of Alberta Convocation Hall. Most of the time, the Archbishop, Lieutenant Governor, City Mayor and University of Alberta President were present and spoke to the assembly. Many physicians also attended and usually one of them gave the convocation address. The fact that the physicians were selected for this task is a good indication of the relationship which existed between nursing and medicine at the time. Interestingly, it does not seem that any of the sisters spoke at the graduation. Was this a matter of humility? Was it considered improper for a sister to give a public speech at the graduation? Was it because the superior spoke at the hospital banquet and thus it was thought that speaking again would be redundant? It is impossible to answer these questions. However, it is likely that at least some answers to these questions would have been affirmative and would have thus justified the silence of the superior.

---

[729] Ibid., 1933 onward.

[730] Ibid.

[731] Weir, ***Survey of nursing education***, 197.

[732] ASGME, EGHS and Chroniques, 1933 and 1935.

The transmission of Catholic values

Many indicators show that the sisters wished to transmit Catholic values to nursing students. Specific activities were designed to meet the religious needs of the students and it is likely that most were members of the Roman Catholic Church. However, it is clear that there were students from other denominations who were exempt from participation in Catholic activities. Nonetheless, all students were immersed in a Catholic atmosphere. Further investigation would be required to find out if non-Catholic students felt singled out because of their affiliation with other churches. This might have been the case, but it must be understood that common values existed between all Christian denominations and that this probably facilitated their integration into the group. In addition students were well aware that the EGH was a Catholic hospital and that selecting its nursing school implied that Catholic norms would be used.

The permanent symbols of the school were selected in 1911, a few months before the graduation of the first class.[733] Sister Casey, the director, chose three school colors: purple for faith, white for hope and red for charity. Thus, it can be suggested that these colors were selected because of the their association with religious virtues. She also established that *Estote Fidelis* would be the school motto. It is evident here that these words were taken directly from the spiritual testament of Marguerite d'Youville.[734] Data indicates that at least one student was involved in the selection of the school pin.[735] The pin consisted of a metal bar on which was engraved the school motto and from which hung a medallion. A Greek cross was engraved in the middle of the medallion and was surrounded by the inscription *Edmonton General Hospital School for Nurses*. Finally, the medallion was encircled by two branches with leaves (probably laurel leaves). Thus, the medallion included two main symbols, the cross for Christianity and laurel leaves for achievement.[736] In summary, it can be said that the school motto, the school colors and the nursing pin incorporated religious symbols reflecting the faith of the Grey Nuns.

---

[733] ASGME, EGHS, 1911.

[734] See introductory chapter for more details.

It is known that from inception the curriculum included religion courses which were taught by clergymen and that Catholic students had annual retreats conducted by an Oblate priest. Catholic students could also join a sodality, an organization emphasizing Catholic values (the Daughters of Mary).[737] Students were also encouraged to attend mass or services of their own denominations. Significantly, the traditional nursing rituals such as the capping ceremony, usually took place in the hospital chapel and in the presence of a priest, reinforcing the position that nursing was a human service and that God could be served by assisting those in need. Although by virtue of being taught by sisters, EGH students were more exposed to religious principles than if they had been in a lay hospital, it is essential to mention that at the time religious behaviors seemed to be emphasized by all Edmonton schools of nursing. For example, in 1914, the RAH students usually met after breakfast to recite prayers.[738] Similarly, in 1926, the UAH students began their day with an hymn, prayers and a scripture reading.[739]

---

[735] ASGME, EGHS, 1911.

[736] ASGME, EGHS, 1911.

[737] This sodality was first mentioned in the hospital chroniques of 1928.

[738] Dorward and Tookey, ***Below the flight path***, 14.

[739] Wilson, ***To teach this art***, 35.

The Faculty

Until 1937, the school did not have any instructors other than the director who provided all nursing instruction. In 1937, a nursing science instructor was hired and two years later a nursing arts instructor was also employed by the school.[740] The qualifications of these lay nurses could not be determined. However, it is known that the last two directors of this period held a baccalaureate in science.[741] One wonders if the hiring of two instructors and the appointment of a director who was baccalaureate-prepared were measures taken in response to recommendations made by Weir in 1932. Indeed, Weir believed that teaching personnel of nursing schools were ill-prepared for their responsibilities and that instructors with better qualifications needed to be hired.[742] Although it is not possible to conclude that the faculty changes were a direct result of the national survey on nursing education, it is apparent that the school was entering a new phase in which nursing was increasingly seen as unique and independent from medicine. In other words, increasingly it was held that nursing knowledge was required to teach nursing and thus students needed to be taught by nurses.

The 1929 conflict

In concluding the discussion on the 1908 to 1942 era, it is essential to elaborate on the conflict which turned some students against the school in 1929. Although there must have been other occasions when students showed dissatisfaction, the 1929 incident was the only one recorded in the school records and hospital documents. The magnitude of the conflict and the fact that it reached the local press probably explains why data about the event has survived until now.

The chronicles of September 1, 1929, stated that "The nursing students are showing some dissatisfaction and a number of them have expressed grievances against some of the sisters."[743] A few weeks later the chronicles indicated that, in the morning, a delegation of "striking" students met with the Superior to present their grievance and that she had received them with "calm and dignity".[744] This meeting did not solve the problem and the conflict became public the following day, when the *Edmonton Bulletin* published an article entitled: "General Hospital strike of nurses is threatened." It was stated in the article that nursing students were planning to go on strike at 7.30 p.m. unless seven former senior members of the class who had been released were reinstated. The source of this statement was not acknowledged. However, the hospital lawyer, L. Giroux, was reported as saying that there was no serious trouble and that the issue surrounded the reinstatement of two senior students who were considered incompetent by the director. The journalist concluded that no one at the hospital had been willing "... to confirm the rumour of the strike."[745] The following day, another article appeared in the *Edmonton Journal*. The author wrote:

---

[740] ASGME, EGHS, 1937 and 1939.

[741] These directors were at the school between 1937 and 1943.

[742] Weir, ***Survey of nursing education***, 176.

> The word "strike" coupled with "nurse" shocks one's sense of the fitness of things. People could hardly be more startled if the doctors of a whole city announced they would attend no patients after a certain date. It is this peculiar relation of the nurse to the public that makes the present trouble at the General Hospital a matter of public concern. [...] According to the Sister Superior, the whole trouble arose because three nurses in training were informed by those in charge that they doubted if they would ever become qualified and competent to obtain diplomas and so were advised to take other work. There will be general agreement with the stand that when the hospital authorities find that there are girls who will never become good nurses it is a duty to the public, as well as a matter of justice to the girls themselves, to let them go.
>
> There are ninety-five nurses in training at the General Hospital. They would be

---

[743] Free translation. ASGME, EGH, Chroniques, 1 September 1929.

[744] Ibid., 26 September 1929.

[745] ASGME, Newspapers file, ***Edmonton Bulletin***, Friday 27 September 1929.

> taking a most serious step it they walked out. It is to be hoped that these young ladies will realize the responsible position they occupy, the work of public service in which they are engaged, and will do nothing to shake the confidence of the public in that most exacting of all professions, nursing the sick.[746]

Until October first, articles about the topic appeared daily in the *Edmonton Bulletin* and *Edmonton Journal*. On September 29, both newspapers reported that it was impossible to know if the students had been on strike or not, but that the administration of the EGH had met to discuss the issue. The authors of the last two articles published in the *Journal* and *Bulletin* on October 1, 1929, stated that Dr. Jamieson, chairman of the physicians' group had informed them that the situation was back to normal. The article of September 28, 1929, is of special interest because it shows that the journalist did not favour the idea of nurses going on strike. His views were probably shared by the public at large, since even today strike actions by nurses are usually condemned. It can also be noted that the writer's words suggest that he considered that the students should act as professionals and it is thus apparent that the fact that they were students was not an issue for him.

Excluding the entry found in the chronicles of September 28, 1929, the first archival document pertaining to the event was dated October 3, 1929. That day, a telegram was sent at 2 a.m. to the provincial superior who was away from Alberta at the time of the events. It said: "Menace de grève gardes jeudi dernier, pas encore - stop - Définitivement réglée - stop - sa Grace impose administration par séculiers et clergé - stop - nous vous attendons pour décision - stop - réponse s'il vous-plaît."[747] The same day the local superior sent a letter to the assistant general of Montreal. Much of this letter was written in a manner which shows that the recipient was aware of the situation and that even if names were not included she would be able to identify those who were behind the conflict. The content of the letter suggests that the transfer of the school director (in June 1929) had angered a group of individuals and that they were seeking revenge by using the nursing students. She wrote:

---

[746] ASGME, Newspapers file, *Edmonton Journal*, Saturday 28 September 1929.

[747] Quote translation: "The nurses threatened to strike last Thursday, no strike yet - stop - Definitely solved, his Grace his imposing administration by secular and clergy - stop - We are waiting for your decisions - stop - RSVP." ASGME, EGHH, doc. 118, Telegram of Sister M.A. Pépin to Mother Gallant, 3 October 1929.

> Ici on avait décidé en juin [...] que l'autorité compétente dirigerait la barque. Le contraire est arrivé; on ne s'est pas tenu pour battu; à tout prix il fallait trouver le moyen de pénétrer dans la régie interne. On a ameuté de pauvres élèves qui ne comprenaient rien à ce qu'on leur faisait demander: Changer incontinent, avant 7 heures le soir même, cette méthode de renvoyer les élèves et de prendre désormais un comité d'arbitrage composé de Monseigneur et de deux médecins.[748]

The mention of the month of June and the fact that the issue surrounded a sister who had some authority suggest that it is more than likely that the transfer of the school director was central to the conflict, and thus that some individuals were opposed to her departure. This hypothesis is reinforced by the fact that a new director has indeed been appointed during the summer months. It must be stated that this change in leadership was nothing particularly exceptional since the sister who left had been in charge for the usual three year term.

In the same letter, the superior also wrote that the students had informed some physicians of their grievances who, in turn, had pushed their leaders to seek assistance from the Archbishop. He then informed the sisters' local council that he had asked physicians to provide him with a complete list of grievances. Significantly, the superior concluded that "... je veux m'en tenir à la direction du Père Provincial des Oblats: n'accepter aucune assemblée d'un genre nouveau, ne donner aucune explication pour ce qui regarde notre discipline interne ... pour le moment."[749]

---

[748] Quote translation: Here in June some had decided [...] that the competent authority would direct the ship. It did not happen, but they did not accept defeat; at all costs they had to find the means to penetrate the administration. They pushed some students to act about a matter which they did not understand: change immediately, at 7 p.m. tonight, the method by which students are released and establish an arbitration committee made of the Bishop and two physicians. ASGME, EHH, Doc. 119. Letter of Sister Duckett to the Assistant General of Montreal, 3 October 1929.

Prior events need to be examined in order to understand what was happening. Three letters written in the Spring of 1929 indicated that the school alumnae was likely behind the students' rebellion. On March 3, 1929, Mrs Larson, the president of the alumnae wrote to the provincial superior to inform her that the members of the alumnae were opposed to the transfer of Sister Laverty (director of the school) because she was well respected and was a member of the University of Alberta nursing examining committee.[750] The type of reply she received could not be determined. However, the alumnae members were obviously dissatisfied since a month later she sent a petition signed by 22 of them.[751] It is evident that these pressures did not alter the decision which had been taken by the order. Interestingly, it seems that Archbishop O'Leary was aware of the situation and that he was opposed to the transfer, since on July 28, 1929, the provincial superior wrote him a short note in which he was informed that the order would not fulfil his wish of seeing Sister Laverty remain in Edmonton.[752] Based on this correspondence, it is likely that confronted with defeat the alumnae waited for an appropriate occasion to contest the authority and thus pushed the students to ask for an arbitration committee when a few of them were asked to leave in September 1929.

It is also apparent that some physicians became involved and considered that the archbishop could be a strong ally since they advised the students to consult him and that in turn he asked three of them to draw a list of grievances. The physicians complied with his request and on October 8, 1929, a list was forwarded to Archbishop O'Leary.

---

[749] Quote translation: "I intend to rely on the advice of the Provincial Superior of the Oblate Priests: not to accept any new types of meeting, not to provide any explanations about our internal discipline... for now." Ibid.

[750] ASGME, EGH Document historiques de l'école (EGHSH) doc. 5, Letter of Mrs. Larson to the Provincial Superior, 3 March 1929.

[751] ASGME, EGHSH, Doc 6, Letter and petition of alumnae to Superior provincial, 12 April 1929.

[752] ASGME, EGHSH, Doc. 10, Letter of Sr Gallant to Archbishop O'Leary, 28 July 1929.

The physicians stated that cooperation had been lacking for some time between those in charge, the medical practitioners and the nurses. They also wrote:

> We also feel that the Superintendent of Nurses should be one of more mature experience to command the confidence and respect of the nursing students. Also that the Sisters in charge of the various departments of the hospital, in order to properly instruct the nurses under their supervision, should be able to understand and speak the English language fluently. We are of the opinion that there are too frequent changes in the heads of departments for the good of the institution. We would recommend that a board of arbitrators or appeal be appointed and composed of three sisters, three doctors, and a representative of your Grace...[753]

On October 28, 1929, three priests who had been appointed by Archbishop O'Leary wrote to the provincial superior and suggested that the local superior be replaced, that a board of appeal be appointed (including a representative of the archbishop), and that sisters of English origins be appointed when possible.[754] Obviously, the provincial superior sought advice from Montreal, since on November 11, 1929, a letter was received stipulating the decisions of the General Council. Significantly, these decisions were preceded by the following statement:

> Aimons notre belle langue française et gardons-la fidèlement; mais il ne serait pas digne d'une Soeur de la Charité de se laisser conduire par l'esprit des nationalités; qu'on ne s'y laisse entrainer par personne. Ne voyons en tout prochain que les enfants du Père Eternel, des frères par conséquent. C'est d'ailleurs l'example que nous a laissé notre Vénérable Mère.[755]

---

[753] ASGME, EHH, Doc. 120a. Letter of Drs Harrison, Peticlerc and Jamieson to Archbishop O'Leary, 8 October 1929.

[754] ASGME, EHH, Doc 121, Letter of Reverends J.C. McGuigan, O'Neil and Retchen to Mother Gallant, Provincial Superior, 28 October 1929.

[755] Quote translation: "We shall love our beautiful French language and we must protect her faithfully; but it would not be proper for a Sister of Charity to be conducted by the spirit of nationalism; we must see in all beings the children of our Eternal Father,

The decisions of Montreal were firm and clear. The Superior General wrote that it would be appropriate to remind everyone that the sisters were in charge of the school of nursing and that the release of the two students was well justified and that it was out of question to form an appeal board. Further, she pointed out that students already had means of appeal since, if they were not satisfied of a decision of the director, they could go to the hospital superior, and if still not pleased, to the provincial superior. She also wrote to remind physicians that if they were not content they had to follow the same lines of authority. She firmly indicated that the superior of the hospital would not be changed and that the administration would remain the same. Finally, in respect of the language issue she suggested that if any sisters had problems with English it would be appropriate to have them take lessons. However, she wrote that the competence of a sister was not a function of being French or English but that efforts would be made to appoint English speaking sisters when some sisters would be available.[756]

Based on the letters of the physicians, priests and Superior General, it is evident that the language/cultural question was one of the issues of the conflict. Interestingly, the director of the school who had been transferred in June, 1929 was of Irish origin and had been replaced by a French Canadian sister. The reply of the Superior General made clear that the sisters were in charge and that they would not take orders from anyone. It is important to recall that few Grey Nuns were of Irish/English origin and that this in itself made more difficult the appointment of sisters of this group to administrative positions. However, the data presented in Chapter 11 shows that over time the sisters whose mother tongue was English were more than well represented in the hospital hierarchy.

In respect of language, it is also interesting that the Superior General

---

thus our brothers. It is indeed the example left by our Venerable Mother." ASGME, EHH, Doc. 122, Letter of Superior General Dugas to Provincial Superior Gallant, 11 November 1929. The reference to Mother d'Youville is understandable since she had provided shelter to injured British soldiers during the conquest war.

[756] ASGME, EHH, Doc. 123. decisions of General Council.

recommended that caution be taken in order to avoid conflict based on nationality. It is not known if the General Council was aware of what had been published in the French Canadian weekly of Edmonton, but it is obvious from one article that nationality was seen by some as the key issue. On October 2, 1929, Rodolphe Laplante published the following in *La Survivance*:

> Les étudiantes gardes malades disent: "Vu que dans ce pays la majorité des gardes ne comprennent pas le français et VU QUE L'ANGLAIS EST LA LANGUE OFFICIELLE, nous "réclamons que les Soeurs chargées des départements sachent parler couramment l'anglais." [...] Cette mention que nous sommes dans un pays anglais pue le fanatisme. Disons ici que toutes les religieuses, moins une, parlent très convenablement l'anglais. [...] les soeurs sont des infirmières diplômées. La compétence ne se pose donc pas. Il reste donc la question de la race et de la langue. C'est une crise intérieure de fanatisme alimenté du dehors. [...] C'est là un aspect seulement de la campagne ourdie et menée contre nos institutions catholiques.[757]

According to the context of the time and the evidence found in the primary data, it appears that the interpretation of Rodolphe Laplante was probably close to reality. Two questions need to be asked: Why did the students select striking as the best pressure tactic? Who was behind the movement and why did it emerge? It may be suggested that the idea of using strikes as a weapon probably came from the rising popularity of this means of negotiation in Edmonton.[758] As stated, it appears that students were pushed to act upon the release of two of their classmates. Evidence suggests that members of the alumnae as well as physicians were behind or involved in the upsurge. However, at least two outside forces may have played a role in this conflict. Laplante mentioned that French Catholic institutions were being threatened. The Ku Klux Klan was also active at the time in Edmonton and it is known that it specifically targeted French Canadian institutions.[759] Although it is unlikely that the Klan was directly involved in this case, it must be understood that its anti-French positions may have agitated some individuals who normally would have been more tolerant.

---

[757] Quote translation: The student nurses say: "Since in this country the majority of nurses do not understand French and SINCE ENGLISH IS THE OFFICIAL LANGUAGE, we request that the sisters in charge of nursing units be able to speak English" [...] This mention of being in an English country stinks of fanaticism. Lets say here that all nuns, but one, speak English very well [...], the sisters are graduate nurses. This shows that they are competent. The only thing left is the question of race and language. This internal crisis is fed from external fanaticism. [...] This is only one aspect of the denigration campaign that is conducted against our catholic institutions. ASGME, Newspapers file, Rodolphe Laplante, "Tempête dans un verre d'eau" (Translation of title: "Tempest in a tea pot"), ***La Survivance***, 2 October 1929.

It is also believed that in this conflict internal struggles within the Catholic Church played an important role. This was seen in the manner in which some clergy members became involved and in the type of solutions which were proposed. The apparent alignment of Archbishop O'Leary with the dissident students and physicians, the fact that the director who had left was Irish Canadian and that she had been replaced by a French Canadian sister, and the seeking of advice from the Oblate Priests, who incidently published *La Survivance*, suggest that conflicts between French Canadian and Irish Canadian Catholics were not foreign to the conflict. Although these two groups shared the same faith, tensions regularly arose between them especially in respect of the issues surrounding Catholic schools and the language of instruction and about the control of the Canadian Roman Catholic Church in general.[760] In Alberta, the rise of inter-Catholic conflicts became perceptible when the Irish O'Leary replaced the French Legal (who had passed away) as head of the Edmonton Church. It is widely accepted that the passage from a French to an Irish leadership brought much tension in the Catholic Church of Alberta. The massive replacement of French Oblate priests by Irish priests was certainly the most salient source of discord.[761] It seems that the Grey Nuns kept a low profile and declined to take part in these conflicts originating in the male hierarchy. It must be noted that it was against the sisters principles to engage in conflicts based on ethnicity and they seemed to believe it wiser to remain outside the priests' squabbles. The sisters must have realized that their position in the province was quite secure and that they could not be replaced as easily as parish priests. In particular, any search for an English Canadian sisterhood to replace them would have been difficult since most Canadian female religious orders were French Canadian. The Grey Nuns were also the owners of the EGH which constituted an effective protective mechanism and significantly they were under the authority of the Motherhouse, reporting directly to the Vatican. However, it is clear that when attacked, the Sisters reacted and used their power to do as they saw fit. As was the case in the conflict of 1929, the male hierarchy did not succeed in imposing its views and the *status quo* was maintained.

---

[758] See Chapter 12 for more details.

[759] Palmer and Palmer, ***A new history of Alberta***, 204. See Chapter 8 for more details.

[760] See: Robert Choquette, ***Language and religion. A history of English-French conflict in Ontario***, (Ottawa: University of Ottawa Press, 1975). Although his work focused on the Ontario school question, he demonstrated the extent to which the problem took national proportions and how the Irish and French hierarchies of the Roman Catholic Church were struggling for control and power; Yves Tessier, ***A l'ombre du Vatican***, (Quebec: Editions Tessier, 1962) 62-66. Similar struggles took place in Manitoba and although very succinct the analysis provided by Tessier addresses well the

Education and life from 1943 to 1967

Many changes took place during these 25 years. Nursing education increasingly became the realm of nursing instructors, and although students were still part of the

---

involvement of Rome in the Manitoba school question.

[761] Raymond Huel, "Gestae Dei Per Francos: The French Canadian experience in Western Canada," in ***Visions of the New Jerusalem - Religious settlement on the Prairies***, ed. Benjamin G. Smillie, (Edmonton: Newest Press, 1983), 38-53; André Lalonde, "Les Canadiens français de l'ouest: espoirs, tragédies, incertitudes," in ***Du continent perdu à l'archipel retrouvé - le Québec et l'Amérique française***, ed. R. Louder and Eric Waddell, (Quebec: Presses de l'Université Laval), 92-93; Robert Choquette, "Problèmes de moeurs et de discipline ecclésiastique: les catholiques des Prairies canadiennes de 1900 à 1930," ***Histoire Sociale/Social History***, 8 (1950): 108-113; Raymond Angus Maclean, "The history of the Roman Catholic Church in Edmonton," (M.A. thesis, University of Alberta, 1958), 142.

workforce, their life gradually became similar to that of other students.

Curriculum and instruction

Although there was no evidence of curriculum changes at the beginning of this period, the hiring of a clinical instructor in 1943 marked the beginning of a new era. The publication by the CNA (in 1940) of a curriculum addendum specifically designed to address clinical teaching shows that educators believed that the topic of learning in the clinical field had to be revisited.[762] In particular, the curriculum committee believed that clinical experiences needed to be more closely supervised and that better guidance would be beneficial for nursing students as well as patients. The basic position of the group was that students needed to be taught in clinical areas just as they were in the classrooms and that clinical practice and theory had to be complementary. Significantly, they recognized that the performance of students in clinical practice settings had to be objectively evaluated and they thus designed a clinical evaluation form.[763] It is not known if the EGH used such form prior to the 1940's. However, a form used during the 1940's was preserved and interestingly it was very similar to the one proposed by the CNA. It is thus possible that the sisters may have been influenced by the form designed by the national association. Students were evaluated on 11 dimensions including: accuracy, conscientiousness, reaction to criticism, interest in work, memory, neatness in work, observation skills, punctuality, professional behavior, personal neatness and economy. Guiding questions were included to facilitate the work of the evaluator. For example, observation skills were assessed by answering the question "Does she note the changes in the mental and physical conditions of the patient?", while interest in work was evaluated by questions such as "Does she utilize opportunities for increasing her clinical knowledge? Is she curious?"[764]

---

[762] Canadian Nurses Association, ***A supplement to a proposed curriculum for schools of nursing in Canada***, (Montreal: CNA, 1940). This supplement was written by the committee who had designed the curriculum of 1936. Significantly, the committee was chaired by Marion Linderburgh whose reputation as a McGill nursing educator was well known.

[763] Ibid., 85-89.

In the late 1940's, the Catholic Hospital Association of Canada began to show greater interest in the field of nursing education. Although it is believed that this renewed concern was primarily occasioned by the shortage of nurses it nevertheless lead to the questioning of old practices and sometime during that decade a program of school inspection was established by the association. The EGH school was visited for the first time in 1947[765] and a month later two Grey Nuns of Alberta went to the Motherhouse to take a course on administration and evaluation of schools of nursing.[766] It appears that school evaluation became the key issue of the 1950's. In 1953, the CHAC organized a nursing committee whose purpose was to study the topic of accreditation. Sister Denise Lefebvre, a Grey Nun, was put in charge and in 1956 she visited all Catholic schools of Alberta, evaluated them and provided them with individual feedback.[767]

It was also during the 1950's that the CNA began to consider involvement in accreditation. In 1958, the CNA sponsored a pilot project the main purpose of which was to determine the feasibility of a national accreditation program. Helen K. Mussallem was appointed director and the project was completed in 1960.[768] Results of the survey showed that nursing education needed much improvement. Specifically, it was found that many of the weaknesses identified by Weir in 1932 still existed and that if an accreditation program was put in place the majority of diploma schools would not meet minimum standards.[769]

---

[764] ASGME, EGHS, Doc. 5. Clinical evaluation form.

[765] ASGME, EGH, Chroniques, 30 March 1947, Sister Mandin, a Grey Nun of Saskatoon was the CHAC visitor.

[766] Ibid., 11 April 1947.

[767] André Cellard and Gérard Pelletier, ***L'histoire de l'Association Catholique Canadienne de la Santé - Fidèles à une mission***, (Ottawa: ACCS, 1990), 84; Thérèse Gastonguay, ***A mission of caring the Catholic Health Association of Alberta, a chronicle of the first fifty years***, (Edmonton: CHAA, 1991), 46; Sister Lefebvre was well prepared for the position. She was at time completing her doctoral degree in pedagogy. She graduated from the *Université de Montréal* in 1955 and thus became the first Canadian nurse prepared at the doctoral level.

[768] Hellen K. Mussallem, ***Spotlight on nursing education, the report of the Pilot Project for the evaluation of schools of nursing in Canada***, (Ottawa, CNA, 1960). Mussallem was a doctoral student at the time. She was studying at Columbia University where she obtained an Ed.D. in 1962. It must be noted that Sister Lefebvre was also

It is evident that this ferment over nursing education and school evaluation became the catalyst for change at the EGH. In 1954, the block system was introduced,[770] a system which was considered an improvement since it insured that theoretical instruction was given prior to the related clinical experience. Significantly, a year later, the nursing school also became independent from nursing service. In concrete terms this meant that the director of the school was no longer responsible for the hospital department of nursing.[771] Following this change, the curriculum was revised and by 1959 all modifications were in place. Beginning in 1956, a mental health affiliation began to be provided at the Oliver Provincial Institute (later the Alberta Hospital Edmonton).[772] Considering that the same year the RAH organized a similar affiliation with the same institute, it may be suggested that by that time a mental health clinical rotation may have been a mandatory requirement.[773] In order to glean the full benefits of the block system a master rotation was adopted in 1959. However, it must be noted that the needs of the hospital were still a priority: "This plan assures a stable number of personnel in the clinical field and guarantees that each student is certain of the experience in each area for a proper length."[774] In this curriculum students received

---

involved in the CNA project.

[769] Ibid., 90.

[770] ASGME, EGHSH, 1954; The block system began to be used at the RAH in 1952, Dorward and Tookey, ***Below the flight path***, 69.

[771] ASGME, EGHS, 1855.

[772] ASGME, EGHS, 1956-1959.

[773] Dorward and Tookey, ***Below the flight path***, 70.

[774] ASGME, EGHS, 1959.

2,035 hours of classroom instruction and 1,324 hours of clinical experience.[775]

After 1955, the school began to submit annual reports and the report of 1965 indicated that further curriculum changes had been implemented. Of note is the fact that the school administration wished to assert its independence from nursing service. Concrete measures were taken in this regard. For example, it was decided to discontinue the two-week senior operating room experience. The director wrote: "Unwarranted amount of time is required to reorientate [sic] students to this department. It also appears to violate the principles of correlated theory and practice. Consequently, the experience was geared to nursing service needs rather than on educational experience for the students."[776] Her report also indicated that the curriculum was by then based on a "needs framework". It is likely that this was the first integration of a nursing model in the EGH school curriculum and it is plausible that the "needs framework" referred to was based on the work of Virginia Henderson.[777] Considering the mention of a framework, it appears that the faculty of the EGH school was aware of new trends in nursing and in particular of the steps being taken towards theory development.[778]

It is of interest to present the available data about the school curriculum of 1964-1965. The *School Bulletin* of 1964 stipulated that the curriculum had been developed by the National League for Nursing, which was regularly employed by Canadian schools of nursing. However, the Catholic nature of the EGH was quite evident in nursing education. The school philosophy read as follows:

---

[775] Ibid.

[776] ASGME, EGH, School of nursing annual report 1965-1966. Prepared by Sister Cécile Leclerc, director of the school.

[777] By that time a French version of Henderson's model was available. The first edition had been published in 1960 by the *Association des infirmières et infirmiers de la province du Québec* (Virginia Henderson, ***Principes fondamentaux des soins infirmiers***, (Montreal: AIIPQ, 1960) and the model was spreading rapidly in French speaking institutions. The Gey Nuns seemed to favour Henderson's approach since they also decided to implement it at the *Institut Marguerite d'Youville* (later faculty of nursing) which still used the model in 1981.

[778] Nursing models began to be developed in the United States during the 1950's. Like most early "theorists" Henderson was a graduate of Columbia University's Teachers College. For more details see: Afaf Ibrahim Meleis, ***Theoretical nursing, development and progress***, Philadelphia: J.B. Lippincott Company, 1985), 13-15.

> Education in the Edmonton General Hospital School of Nursing is based on the Catholic philosophy of life. Emphasis is placed on the human personality and on man's eternal destiny. The educational program is designed to aid the individual student to develop the physical, intellectual, moral, spiritual and cultural aspects which will enable her to adjust to her personal, professional and social obligations and to attain eternal happiness.[779]

The two aims of the program were congruent with the stated philosophy:

> To fulfil the spiritual aim of the curriculum, the School endeavours to assist the student to understand and practice her duties toward God, neighbour and self. She will recognize that she has a definite responsibility not only for her own soul, but also for that of her patient.
>
> To fulfil the professional aim of the curriculum, the School endeavours to guide the student to attain knowledge, skills, attitudes, and ideals of nursing, so that she will be prepared to contribute her share to the care of the ill; the prevention of disease, the promotion of health and community welfare, and to give total nursing care in first level positions of professional nursing.[780]

Seven objectives were used to reach these aims:

1- To instill into qualified young women aspiring to the nursing profession the Christian ideals of nursing and a Christ-like attitude toward the ill and afflicted.

2- To contribute to the physical and moral development of the student by providing facilities conducive to healthy, happy living.

3- To develop an understanding of the total resources of the patient, his family and the community, in order to plan and render the health care and teaching he needs.

---

[779] ASGME, EGH, School of nursing file, School Bulletin of 1964, 6.

[780] Ibid.

4- To develop an understanding of the nurse's role in health promotion, disease prevention and community welfare.

5- To contribute to the student's moral and spiritual growth through formal instruction as well as supervision of activities sponsored by various groups and hospital departments.

6- To provide for social growth through a guided program of varied social activities.

7- To develop a questioning mind and a desire for continuous professional, intellectual, social and cultural growth.[781]

It is readily apparent that these objectives were student centered and that they reflected the holistic philosophy and aims of the school. Indeed, objectives 1 and 5 were related to spiritual growth, objective 2 to physical growth, objectives 2 and 5 to moral growth, objectives 6 and 7 to social growth and objectives 1,3,4,5,and 7 to professional and intellectual development.

In 1964-1965, the program included 350 hours of biological sciences distributed among five topics: anatomy and physiology (105 hrs), microbiology and pathology (50 hrs), pharmacology (60 hrs), normal nutrition (35 hrs) and diet therapy (70 hrs). These courses were all taught by nursing instructors. However, a dietician was also involved in the nutrition and diet therapy courses. Social sciences were taught in 7 courses for a total of 215 hours: philosophy and logic (15 hrs), psychology (20 hrs), sociology (30 hrs), Christian doctrine (60 hrs), medical ethics (15 hrs), history and trends in nursing (15 hrs) and professional development (60 hrs). Clergy members taught philosophy and logic, and medical ethics. They also collaborated with nursing instructors in the teaching of psychology, sociology and Christian doctrine. History and trends in nursing and professional development were the entire responsibility of nursing instructors. The core nursing content included 1,350 hours of nursing science and clinical practice. An important principle was that theoretical and clinical experiences were integrated. Clinical nursing was divided into five topics. Fundamentals of nursing (242 hrs), medical surgical nursing (688 hrs) in which 30 hours of community and public health nursing were integrated,[782] obstetrical nursing and care of the newborn (120 hrs), nursing of children (120 hrs), psychiatric nursing (120 hrs) and advanced nursing (60 hrs). Nursing instructors were involved in the teaching of all of these subjects. Although, physicians still took part in all nursing courses except for the first and last (fundamentals and advanced nursing) their participation was more marginal than in the past.[783]

---

[781] Ibid., 7.

The calendar description of the advanced nursing course provides a good description of what was expected from graduating students:

> This course integrates through seminar discussion the integral components of the curriculum into a unified whole. The student is able to continue her progression of learning of comprehensive nursing care; of nursing as an art and a science which involves the whole patient - body, mind and spirit; promoting his spiritual, mental and physical health by teaching and by example stressing health prevention as well as ministration to the sick and involving the care of the patient's total environment - social and spiritual, as well as physical and to give health service to the family and the community as well as the individual.[784]

This description is also interesting because it shows that nursing was seen as an art and a science, concerned with health and illness, and that patients had to be considered as whole persons. Nursing was also considered to be a service to be provided to individuals, families, and communities. It is evident from the School Bulletin of 1964-1965 that the curriculum was increasingly similar to that of later years. In general, the emergence of nursing as a distinct academic discipline was reflected by the development of nursing knowledge and by increasing control over nursing education by nurses. The EGH school recognized that further changes were needed and even if a new curriculum had been adopted in 1964-1965, the school embarked on revisions which ultimately led to the creation of a two-year program established in 1968.

---

[782] Community health placements began in 1961, when third year students spent one week at the Sturgeon Health Unit. ASGME, EGHS, 1961.

[783] ASGME, EGH, School of Nursing file, School Bulletin of 1964, 18-25.

[784] Ibid., 25.

Leisure and recreational activities

Student activities were similar to those of the previous period. However, activities became more structured. In particular, the choir became an official Glee Club in 1947, and from then on it was lead by a musical director.[785] The students of the 1950's and 1960's regularly participated in inter-hospital talent contests and sports weeks.[786] There is evidence that during the 1960's the students had an official student association, since in 1960 the president went to the Alberta Association of Registered Nurses (AARN) annual meeting. In subsequent years the students' association usually sponsored two students to go to the AARN or CNA conventions.[787] In the 1960's the student body organized at least two debates. In November 1962, the students entertained the question: "How do nurses today compare with nurses of yesterday?" and in March 1963, they debated on the issues of the continuation of employment after marriage. These debates seemed to be quite formal since three judges were appointed to proclaim the winning team. Of interest, the judges of 1962 were a physician, a lawyer and a representative of the AARN.[788] Although debating topics could be identified for only two years, it must be noted that the selected subjects indicated that the students were aware of some of the professional issues of the era. The delegation of students to professional meetings and the organization of debates show that the student association encouraged activities related to professional development. Of course, it was also involved in leisure activities. A fall school dance, a winter carnival and a spring fashion show were organized almost every year, most of the profits going to the graduating class.[789] Significantly, the proliferation of these activities suggests that nursing students were increasingly enjoying the social life of "normal" students. The fact that during the 1960's third year students were also given permission to live elsewhere than in the school residence also indicates that nursing education was being normalized.

---

[785] ASGME, EGHS, 1947 onward. At least three men took turns at directing the group, two of whom were French Canadian, including a member of the Lorieau family whose musical talent is well known in the Franco Albertan community.

[786] Ibid., 1955 onward.

[787] Ibid., 1960 onward.

[788] Ibid., 1962 and 1963.

Graduation

Graduation ceremonies continued to be elaborate and to take place at the University of Alberta Convocation Hall until 1962 when the ceremony was transferred to the Jubilee Auditorium. The archbishop, the lieutenant governor, the mayor and the president of the University of Alberta continued to be present at the event. Interestingly, it was noted that when the president of the university could not attend, the dean of the Faculty of Medicine was given the role of representing the institution.[790] The fact that the director of the university school of nursing was not selected to represent the institution tells much about the place of nursing on campus at the time. It is evident that nursing was still considered a sub-field of medicine to be controlled by the medical hierarchy.

Mother/daughter teas continued to be held until 1956, when for the first time fathers were also invited. This change must have been seen as an important one since it was recorded that mothers were given a poem written on a parchment attached with a purple ribbon (school color) and a red rose (school flower), while the fathers received a chocolate beer bottle.[791] Inviting the father was probably a new trend citywide since the same policy was adopted at the RAH in 1956.[792]

The transmission of Catholic values

During these years, students continued to have annual retreats and the Daughters of Mary Association was active at least until 1961.[793] It has been already stated in the curriculum section that members of the clergy were involved in teaching and that students had Christian Doctrine courses. The curriculum objectives of 1964 also showed that the Christian ideals of nursing were emphasized. In addition, the 1964 School Bulletin included a statement highlighting the linkages between religion, nursing and feminine attributes:

---

[789] Ibid., 1961 onward.

[790] This occurred at the graduations of 1947, 1948, 1949 and 1950. ASGME, EGH, Chroniques.

[791] ASGME, EGH, Chroniques, 3 May 1956.

[792] Dorward and Tookey, ***Below the flight path***, 70.

> The nurse is first of all a lady. There is no other profession that requires from its members, as totally and as intensively the same qualities that characterize the feminine nature. Thus the profession allows full scope for the blooming out of the feminine personality, both naturally and supernaturally through selfless love, untiring devotion and supernatural kindness. The Christian Nurse is called upon to be spiritually tuned to be worthy of her sacred vocation.[794]

Data about the school also suggests that, at least since 1946, lay symbolism had been combined with religious symbolism. Capping ceremonies had always taken place in the chapel or at the cathedral. However, the chronicles revealed that at the capping ceremony of 1946, all students lit a candle to the candle of another student who personified Florence Nightingale.[795] It is important to note that the association of religion and nursing was not unique to Catholic schools of nursing. For example, in 1965 at the RAH "a chapel service [was] conducted by the chaplain the morning that the students first don[ned] their uniforms."[796]

The faculty

Although the number of faculty members was not available for the first years of the period under study, the shift towards nursing education taught by nurses is apparent when considering the fact that in 1955-56 the EGH school had only three faculty members, while in 1966-67 there were 21.[797] The preparation of nursing instructors was a key issue raised by Mussallem in her report to the Royal Commission on Health Services in 1964. Based on her CNA findings of 1960, she reported that only 25% of the nursing instructors of the 171 diploma schools of the country had a baccalaureate level preparation or more[798], 44% were educated at the certificate level and 31% did not have more than a nursing diploma.[799] In 1955-56, 33.3% of the EGH school teaching staff had a baccalaureate degree, 20.5% a certificate, and 46.2% only had diploma level education. By contrast, in 1966-67, 33.3% held at least a baccalaureate degree (the director held a master's degree), 28.5% had completed a certificate and the number of staff members with only diploma level education had been reduced to 38.2%.[800] Compared with the national averages of 1960, these results show that although the EGH school had a greater percentage of baccalaureate prepared instructors, it had a larger proportion of staff who were diploma educated, while the number of staff with a certificate was lower than the national figures. It may be suggested that the larger proportion of baccalaureate prepared staff compensated for the larger percentage of diploma staff. Mussallem's results are not sufficiently detailed, however, to suggest that the EGH was atypical.

---

[793] ASGME, EGH, Chroniques 1943 to 1966.

[794] ASGME, EGH, School of Nursing file, School Bulletin of 1964, 6.

[795] ASGME, EGH, Chroniques, 1946.

[796] Dorward and Tookey, ***Below the flight path***, 85.

It is clear that efforts were made between 1956 and 1967 to improve faculty preparation. The school chronicles stated that in 1956 the "... hospital encouraged and facilitated members of the faculty by sending them to conventions, institutes and workshops where they could particularly benefit."[801] Coincidently, in 1958, the hospital's superior began to yearly award a one thousand dollar scholarship to nursing instructors who wished to pursue further education.[802] It seems that the practice of taking courses in the summer became common for EGH instructors. For example in 1960, three instructors were sent to Spokane for a special nursing course and another attended a workshop in Seattle while taking courses at the University of Alberta. It is evident that the EGH believed it had to respond to outside pressures since the school chronicles revealed that: "In view of the CNA recommendations and report of the Pilot Study the school of nursing must make an effort to have better prepared staff."[803] The involvement of faculty members in professional associations was also encouraged during the 1950's and 1960's.[804] For example, in 1955-56 and in 1962-63 three instructors were members of committees of the AARN.[805]

---

[797] ASGME, EGH, School of Nursing file, Annual reports 1955-1956 and 1966-1967.

[798] Twenty-two percent had a baccalaureate degree and only 3% master's preparation. Mussallem, ***Nursing education***, 48.

[799] Ibid.

[800] ASGME, EGH, School of Nursing file, Annual reports of 1955-56 and 1966-67.

[801] ASGME, EGHS, 1956.

The *Collège Saint-Jean* era, 1968-1972

Significantly, the EGH School of Nursing was the first hospital school of the province to be transferred to a college setting. It is thus of interest to elaborate on this unique aspect of the history of the EGH. As far back as during the 1930's the Canadian Nurses Association had began to advocate that nursing schools should have budgets independent of hospitals, and that ultimately nursing education should be transferred to the mainstream education system. Taking into account these positions, the curriculum guide of 1936 had been planned as an interim measure. However, the writers of the guide recognized that the transfer would be gradual and that it would take a number of years before all hospital schools would be eliminated.[806] Evidently, progress was so slow that in 1948 the CNA secured funding from the Canadian Red Cross in order to establish a demonstration project. Basically, the funding was used to enable the demonstration school, located in Windsor Ontario, to function without financial assistance from the hospital.[807] This independence permitted the school program to function separately from nursing service. This meant that students could complete their program of study in two years instead of three. Unfortunately, at the end of the project in 1952 the school returned to the old system, even though in the evaluation of the project it was concluded that the model which had been demonstrated offered an efficient alternative to the longer program where the student provided service to the hospital.

---

[802] Ibid, 1958.

[803] Ibid.

[804] It must be noted that information about faculty involvement in professional associations was recorded in the school annual reports which were only available only after 1955. Prior to that year the director of the school had also been the director of nursing. Logically, the recording of faculty members activities must have been part of the director of nursing's report. Unfortunately, it is not known if such reports were ever written and if it was the case it does not seem that any were preserved.

[805] ASGME, EGH, School of Nursing file, Annual report, 1955-56 and 1962-63.

However, the tenacity of the CNA began to pay off in the late 1950's when issues concerning nursing education were increasingly reaching the agenda of provincial and federal policy makers. In fact, it may be suggested that the CNA capitalized on the post-war climate. The shortage of nurses and the planning of national health care reforms provided avenues through which nursing associations could be heard. In particular, the creation of the Royal Commission on Health Services (RCHS) provided a highly publicized forum which was well utilized by nursing leaders. In its final report, the RCHS endorsed the key recommendation of the Canadian Nurses Association in relation to nursing education which was that the length of nursing programs be reduced to two years and that the authority to operate them be transferred to educational institutions.[808] The selection of Judge Emmet Hall (Chief Justice of Saskatchewan) as head commissioner and of Alice Girard (professor of nursing at the *Université de Montréal*) as the nursing representative seemed to be advantageous for the profession. Both were well prepared for the task. Hall had been a legal advisor for the Grey Nuns hospitals in

---

[806] CNA, ***Proposed curriculum***, 238.

[807] Janet Ross Kerr, "Educating nurses for the future," in ***Canadian nursing issues and perspectives***, 238.

[808] Government of Canada, ***Royal Commission on Health Services***, vol. 1, (Ottawa: Queen's printer, 1964), 64-69.

Saskatchewan and Girard, who had been president of the CNA from 1958 to 1960, was the only woman and the only French Canadian commissioner.

It must be noted that in 1962, in the midst of the RCHS investigation: "...the Saskatchewan Registered Nurses Association gave full approval to the Regina Grey Nuns' Hospital School of Nursing to conduct a two-year diploma nursing experimental program." This event was a significant one for Saskatchewan since the report of an evaluation published in 1968 was conclusive enough for the province to begin reforms which led to the establishment of a two-year pattern of nursing education in the province.[809] Simultaneously, Saskatchewan opted for a gradual transfer of nursing education to community colleges.

Following publication of the RCHS Report, the Quebec and Ontario governments acted decisively and, less than ten years after the publication of the Report, all nursing diploma programs had been transferred to community colleges. In Quebec, the whole society was in a mood for change (referred to as the "quiet revolution"), and the province engaged in a complete reform of its education system which led to the creation of the CEGEP (Collège d'enseignement général et professionel) system. As soon as these colleges were created, nursing diploma education became part of their mandate and by 1972 all hospital programs had been closed.[810] The change was also rapid in Ontario where a number of experimental programs had already demonstrated the feasibility of two-year and of college programs.[811]

The situation was much more complex in Alberta, where opposition to two-year programs and to the transfer of nursing education to a college system was very strong. In particular, in 1963, the Nursing Education Survey Committee which had been appointed by the provincial minister of health opposed the transfer of hospital programs to other institutions.[812] It appears that cost was the most important deterrent for the surveyors. They took the view that two-year programs would be more expensive because hospitals would have to hire more graduates to replace the substantial workforce made up by the third year students.[813] Hence, it is obvious that they believed that saving money was more important than providing an education devoid of unnecessary repetition.[814] The Report was filled with seemingly contradictory statements. For example, the Survey team was reported to be opposed to two-year programs because of a belief that superior academic ability was essential for success in that type of program. This was a problem because of the conclusion that the average nursing applicant would not be able to meet the necessary requirements.[815] In the same report they proposed that a school of nursing offering a post-graduate program (undergraduate university credits) be established at the Calgary campus of the University of Alberta in order to improve nursing qualifications.[816] One wonders how the average graduate (more than likely an average applicant when entering diploma education) have been able to meet university requirements if, in the first place, the academic ability to succeed in a two-year diploma program was lacking. It seemed that the Survey team also believed that it was sufficient to have only a small number of candidates sufficiently qualified to seek further education. Based on the Report, it is obvious that the members of the Survey team did not have any understanding of the positive outcomes that university education for nurses could have for patient care, as they were quite satisfied to have only a few nurses prepared at the baccalaureate level. Considered from that point of view, the apparent contradiction of their statements is in fact logical since a diploma education was to be the norm. They wrote: "... to postulate, [...] that all the thousands of nurses needed in this country should be prepared at in university schools or in independent schools under direct university management is unrealistic, uneconomic, an invitation to chaos..."[817] However, they also stated that the separation of nursing education from the hospital was uncalled for since "... the trend in medical education is to closer integration with the hospital..."[818] The acceptance of such a premise reveals the extent of the surveyors' bias. Indeed, a similar statement made about medicine certainly was not meant to propose that medical education should be transferred from universities to hospital schools of medicine.

---

[809] Marguerite Létourneau, SGM, "Trends in basic diploma nursing programs within the provincial systems of education in Canada 1964-1974," (Ph.D. diss., University of Ottawa, 1975), 12.

[810] Ibid., 72.

[811] The Windsor program has already been mentioned. Another experiment took place at the Ryerson Polytechnical Institute of Toronto, which began to offer diploma nursing education in 1964. In Ontario, the transfer of nursing education to community colleges was completed by 1973. Janet Ross Kerr, The origins of nursing education in Canada: An overview of the emergence and growth of diploma programs 1874-1974, in ***Canadian nursing issues and perspectives***, 241-242.

---

[812] Alberta Department of Health, ***Report of the Nursing Education Survey Committee, province of Alberta, 1961-1963***, (Edmonton: Queen's Printer, 1963), 50-51.

[813] Ibid., 195.

[814] They acknowledged that an advantage of two-year programs was the diminution of duplication and redundancy. Ibid., 50.

[815] Ibid., 51.

[816] Ibid., 35.

It is apparent that the Alberta report on nursing education of 1963 lacked vision and that its recommendations were contrary to national trends. Fortunately, in this case, inter-provincial competition has always existed and it may be suggested that the positions taken by Saskatchewan, Ontario and Quebec were probably key reasons the province accepted the establishment of the first two-year program at Mount Royal College in Calgary in 1967, even though Létourneau reported that it provoked much controversy and resistance.[819] However, the pressures exerted by the AARN and nursing educators of the province had kept the issue alive. In light of the opening of the Mont Royal program, it appears that nursing leaders had not been deterred by the 1963 report or by those who wanted to maintain the *status quo* in nursing education. "Political forces exalting changes, persistently paralleled by equally strong opposing forces, were frequently interlocked with pressures to transfer responsibility for the prescription, maintenance and control of standards in nursing education."[820] The strength of the pro-hospital school group was definitely real and led to the bizarre and unique situation of nursing education in Alberta. Indeed, thirty-one years after the publication of the 1963 report, Alberta is the only province where hospital schools of nursing continue to exist. Closure of the schools was announced in February of 1994, however, by a provincial government focused on the elimination of the annual deficit.

---

[817] Ibid., 15.

[818] Ibid., 191.

[819] Létourneau, a Franco-Albertan Grey Nun, is a good source of reference in respect of the climate surrounding the opening of this program since she was a member of the committee set up to plan a strategy for the implementation of the program. She also wrote a brief to the University of Calgary upon which the Board of Governors made the decision to establish a School of Nursing in 1968. Létourneau, ***Trends in basic diploma nursing***, 195.

Having set the stage, it is now possible to examine how and why the EGH School of Nursing was the only hospital school of nursing which made the decision to transfer its nursing program to mainstream education in the 1960's. In July 1965, Sister Ste-Croix who was then the director of the school recommended that the RCHS report be studied in conjunction with developing a long range plan for the school of nursing.[821] A few months earlier she had also sent a letter to the hospital superior in which she called for a complete change in the school of nursing program and in which she stated that the current literature and research recommended that schools of nursing be separate and independent from hospitals.[822] It is thus apparent that the school director favoured change. It was not possible to determine when and how the sisters began to seriously consider new options, but it is clear that by April 1967 the development of a two-year program was well underway. It is interesting that the Sisters of the Misericordia Hospital collaborated in this planning and at that point negotiations were ongoing for the affiliation of the two schools with *Collège Saint-Jean*.[823]

---

[820] Ibid., 240.

[821] ASGME, EGH, School of Nursing file, Annual Report of the school of nursing, 12 July 1965.

[822] ASGME, EGH, School of Nursing file, Letter of Sr Ste-Croix to Sr Superior, 3 February 1965.

It is not surprising that these three institutions were planning to collaborate. The Misericordia school was the only other Catholic school of nursing in the city and the Misericordia Sisters, the Grey Nuns, and the Oblate Priests (who owned *Collège Saint-Jean*) had been associates in a number of projects throughout Alberta's history. Significantly, their religious faith was not their only common trait as most members of the three orders shared a common cultural French Canadian and French heritage. In addition, the motherhouses of both nursing orders were in Montreal where nursing education was rapidly being modified. However, for reasons which could not be entirely explained, the Misericordia school eventually withdrew from the project which was finally implemented by the EGH and *Collège Saint-Jean*.

It will be seen that the move of the Misericordia Hospital to another site (in the summer of 1968) was considered problematic by those who had to approve the plan which called for implementation of the program in the fall of 1968. However, it may have been the case that the Misericordia staff was not as convinced about the advantage of an affiliation with *Collège Saint-Jean* as those at the EGH. At the joint meeting of April 10, 1967, Sister Leclerc (who was the new director of the EGH school) stated that all instructors should at least be educated at the baccalaureate level. This was not a problem for her school, since all instructors who did not have a degree were working towards this goal. One wonders if Misericordia school staff members may have been less educated and placed lower value on a general educational base for nursing; and also if this could not have been among the factors which impelled that hospital to withdraw from the project. At the same meeting, Sister Leclerc reminded the audience that fewer than three percent of Canadian nurses had a baccalaureate education and that in light of this fact, it might be wise to develop a degree program. It is evident that her position was not supported by all present, since it was stated in the minutes that there were mixed feelings about the suggestion, even if everyone believed that the new program should not be terminal.[824] It does not seem that Sister Leclerc pushed the issue any further, even if developing a bilingual degree program could have been advantageous.

---

[823] ASGME, EGH, School of Nursing file, Minutes of the joint meeting on two-year nursing program, Edmonton General and Misericordia Hospitals, 6 April 1967.

At the following meeting the EGH committee presented the rationale for the proposed changes and the Misericordia committee submitted a philosophy for the new program. Seven justifications for change had been identified by the EGH staff members:

1- For a nursing program to be consistent with sound educational principles, it must be centered in an educational setting and the service component be removed.

2- By providing course in general education:

   a) the quality of service given to patients will be improved

   b) personal development of the student will be broadened by the sharing of experiences with those in other disciplines.

3- Pooling of resources and personnel by utilizing the most qualified instructors, adequate facilities and learning experiences will upgrade the standard of education and be more economical.

4- By controlling the students' learning experience and carefully selecting candidates, the nursing program could be accelerated at the same time by broadening the students' educational program.

5- Courses provided at the college will be recognized as credits in order to motivate students to further their education.

6- By reducing the length of the program the ordinary span of the service given by a nurse in a community will probably be increased by at least one year and possibly more.

7- By elevating standards of nursing education, the program would be more attractive and thereby broaden selection and increase recruitment.[825]

It is evident that these objectives were rooted in the recommendations of the RCHS and that they ignored those of the 1963 provincial survey. Importantly, the service component was to be entirely removed and the broadening of nursing education was a central aspect. The minutes of the meeting revealed that all justifications were agreed upon except the third one. Questions arose about the extent to which the two schools would join, about the usage of both sites by all students, about who would pay the instructors, about who would coordinate the program and significantly, if theory and practice would be separated too much. Since the EGH committee had drafted the document, it is likely that much of the opposition must have come from committee members of the Misericordia school. Even though accommodations were made (item "3" did not appear in the second draft presented on April 14), the eventual withdrawal of that school suggests that some key players of that institution were lukewarm towards the project. In particular, the opposition to item "3" suggests that some must have feared a loss of control and may have seen the project as a threat against the school identity.

---

[824] ASGME, EGH, School of Nursing file, Minutes of a joint meeting of the EGH and Misericordia schools of nursing, 10 April 1967.

[825] ASGME, EGH, School of Nursing file, Minutes of the joint meeting of the EGH and Misericordia schools, 11 April 1967.

Of interest, the second draft of the document included an additional justification. The program will give opportunities "... for bilingual students to receive the courses offered at the College in either French or English."[826] Similarly, the first draft of the philosophy did not include any statements about bilingual education while the second one did include one. It is likely that the addition of such statements was proposed by the representative of ***Collège Saint-Jean***, who probably believed that it was important to clearly state the opportunities provided by his institution. Interestingly, the only other modification of the first draft of the philosophy included statements related to the "Christian atmosphere" which would be provided in the new program. Considering the importance placed upon religious principles by Catholic sisters, it may appear curious that the first draft did not include any mention of Christianity. It is plausible that this omission occurred because all the members of the Misericordia committee were lay individuals. The second draft of the philosophy read as follows:[827]

---

[826] ASGME, EGH, School files, Minutes of joint meeting, 14 April 1967.

[827] Statements added on the second draft of 14 April 1967 are printed in italics.

The Faculty of the Misericordia and Edmonton General Hospital Schools of nursing believe that nursing functions interdependently with allied professions in the promotion of the health and welfare of mankind. *In providing the highly personalized and continuous service, the nurse must appreciate the nature and dignity of man.*

We believe that general education courses are a necessary foundation for a nursing education program aimed at developing the total personality of the student in order to function as a nurse and a member of the community. We believe that nursing education is a continuous process whereby the individual may develop the ability to cope with the demands of a changing society and that this may best be achieved in the environment of an educational institution. *Furthermore, the sociological environment created in a bilingual and Christian atmosphere will enhance the understanding of man.*

Learning refers to changes in behavior which involve self-activity of the learner. The educator has a secondary but dynamic role in guiding the student in her learning experience. We believe that teaching by principles accelerates the learning process as the student may more readily adapt to new experiences. Furthermore, in removing the service component in nursing, learning experiences may be organized to ensure continuity, sequence, correlation, and to foster the application of basic concepts in the rendering of nursing care.

We recognize that by selecting appropriate candidates, controlling the students' learning experiences, and by sharing the existing facilities and resources, the program can be completed in approximately two years. The student would then be qualified to assume the responsibilities of first level positions in nursing.[828]

In June 1967, the EGH/Misericordia/*Collège Saint-Jean* proposal was endorsed by the AARN[829] and on December 17, 1967, the deputy minister of education agreed to "consider a request for interpretation of the legislation to permit grants to *Collège Saint-Jean*.[830] On the same day "Father McMahon indicated that there was a possibility that *Collège Saint-Jean* might, in the distant future, become either part of the University [of Alberta] with specific emphasis on the French atmosphere of the college, or alternatively, it might become a public junior college, with downgrading of the French context."[831] Finally, it was also decided that the time had come to present the nursing project to Dr. Monckton, Chairman of the Committee on Nursing Education of the University of Alberta.[832]

---

[828] ASGME, EGH, School of Nursing file, Minutes of joint meeting, 14 April 1967.

On February 16, 1968, Dr. Monckton wrote to Mr. Gravett (acting executive director of the Misericordia Hospital) to inform him that the University of Alberta committee believed that the two-year program project should be postponed until 1969 since the move of the Misericordia Hospital to its new site[833] would occasion disruptions. The committee also refused to give its approval because of the unclear status of the College.[834] Unfortunately, it is not known if the EGH received a similar letter. It may be suggested however, that the concern about the status of *Collège Saint-Jean* would have also have applied to the EGH school. It appears that in the following days the EGH School of Nursing decided to resubmit a brief in which all mention of the

---

[829] ASGME, EGH, School of Nursing file, Letter of Mona Staves, Nursing Councillor of the AARN to Sister Chaloux, Superior of the EGH, 13 June 1967.

[830] ASGME, EGH, School of Nursing file, Minutes of joint meeting, 17 December 1967.

[831] Ibid.

[832] This committee was responsible for the monitoring of standards in nursing education for the province.

[833] This move from downtown to the west-end took place in July 1969. Gilpin, ***The Misericordia Hospital***, 113.

[834] ASGME, EGH, School of Nursing file, Letter of Dr. Monckton to Mr Gravett, 5 February 1968.

Misericordia School had been deleted.[835] Since Dr Monckton's letter to the Misericordia School was found in the Grey Nuns archives, it is evident that discussion had taken place between the two institutions. However, records of these discussions could not be found. It was therefore impossible to determine how the EGH administration decided to resubmit the proposal independently. Nonetheless, it is clear that the Misericordia completely abandoned the project since the hospital program continued to exist in 1994.

On April 2, 1968, Dr. Monckton wrote to Sister Leclerc to inform her that the University of Alberta committee had approved the two-year program.[836] Of interest, his letter indicated that Dr. Moreau had sent a letter of support. The mention of this letter, which could not be traced, suggests that the support of this well known surgeon positively influenced the committee. This seems highly likely since the brief submitted on April 14 had almost identical to the first one. It also shows that the support of medicine was still a very important factor which could influence the outcome of requests for program changes in schools of nursing.

The green light was thus given to begin the two-year program in September 1968. However, as is often the case in nursing education, funding rapidly became an issue. The 1969 minutes of the Board of Director meetings of the EGH revealed that the provincial departments of health and education were refusing to provide appropriate funding, the department of health arguing that education was responsible for the funding of the program since *Collège Saint-Jean* was involved in it, with the education department maintaining that health was responsible since the school was still part of the EGH.[837] It was not possible to determine which department finally funded the program or if the necessary amount of money was made available. However, this was not the only difficulty.

---

[835] The remaining parts of the document were not modified; they basically included the justifications and philosophy of the program as drafted in April 1967. ASGME, EGH, School of Nursing file, Brief submitted on 14 February 1968.

[836] ASGME, EGH, School of Nursing file, Letter of Dr. Monckton to Sister Leclerc, 2 April 1968.

[837] ASGME, EGH, Minutes of the Board of Directors files, Minutes of 17 October 1969, 4 December 1969, 10 december 1969, 10 January 1970, 23 January 1970.

The minutes of the Board of Directors meeting of September 4, 1970, revealed that on August 5, 1970, *Collège Saint-Jean* had become part of the University of Alberta and that under the new agreement, the college could no longer be involved in professional programs. It appears that the EGH attempted to convince the University to reconsider the possibility of maintaining the nursing program but that permission was denied.[838] It was not possible to determine if the sisters tried to transform the diploma program into a baccalaureate degree. However, it is unlikely that such an attempt would have been successful since the university already had a nursing program which had recently, and with considerable difficulty, been changed to an integrated program (in 1966). There is no evidence to suggest that the sisters sought support from the Franco-Albertan community. It must be noted that the Association Canadienne Française de l'Alberta (ACFA) concentrated its energy on the battle for the provision of elementary and secondary education in French.[839] Even though the ACFA had participated in the negotiations which took place between *Collège Saint-Jean* and the University,[840] it is difficult to believe that the association would have pushed for a nursing program since education was its priority and there was no evidence to suggest that health care was even among its list of priorities.[841]

---

[838] ASGME, EGH, Board of Directors correspondence, Letter from Mr. Pickering to James Henderson, Minister of Health, 20 September 1970. Mr. Pickering stated in this letter that in early August he had approached the University of Alberta Board of Governor and the University of Alberta President without success.

[839] Gratien Allaire, "Pour la survivance, l'association canadienne française de l'Alberta," in ***Les outils de la francophonie***, (Winnipeg: Centre d'études franco-canadiennes de l'ouest, 1988), 75-83.

[840] Ibid., 84.

[841] Questions related to health care are beginning to emerge in the 1990's. The topic of accessibility of health care in French was discussed in one of the sub-committees at the 1993 general meeting of the ACFA.

Confronted with the change in the status of the *Collège*, the EGH school immediately embarked on a negotiations with Grant McEwan College. When an agreement was reached, the program was entirely transferred to that institution in the fall of 1972.[842] Total transfer was probably unavoidable since the previous affiliation had shown that it was difficult to secure funding for a program jointly operated by a hospital and a college. It is also clear that the sisters did not wish to return to a hospital program, and that although Grant McEwan College was a non-denominational institution the planned collaboration and the provision of clinical experiences at the EGH were seen as sufficient to transmit Christian values to the students.[843]

On August 19, 1973 G.L. Pickering, Executive Director of the EGH, gave the keynote address to the final graduating class of the school of nursing. He stated that the closure of the school did not mean that the hospital was no longer interested in nursing education but that on the contrary:

> ... it was because of our desire to improve nursing education and to bring it in line with advanced thinking on the subject that we made the decision, five years ago, to make such changes as were considered necessary to achieve those objectives [...] We took note of the fact that nursing educators and nursing associations had been advocating a change in the education of nurses for many years and that these changes were well advanced in many Canadian provinces. We could not escape the conclusion that if it is the policy of our society to permit professional groups generally to have overall direction and control of the direction of their membership then this policy should have uniform and equitable relevancy, including its application to the nursing profession. It seems somewhat ironical that the majority of those who are opposing changes in nursing education belong

---

[842] ASGME, EGH, Minutes of the Board of Directors files, Minutes of September 1970 to May 1971.

[843] These considerations were stated in a report recommending the transfer to Grant McEwan College. ASGME, EGH, School of Nursing file: Sister S. Keegan, Sister C. Leclerc and Sister D. Lefebvre, Report concerning the two-year program, May 1971.

> to other professions in the health field which enjoy the very privileges that they are advocating should be denied to the nursing profession. Whenever such a situation as this arises in a society you can be assured that some type of vested interest is being protected.[844]

Importantly, he also said:

> Our experience has now confirmed the results of most of the cost-benefit studies which have been carried out by knowledgeable people and has demonstrated that there is no financial benefit accruing to a hospital in the operation of a properly developed and well conducted nursing education program [...] To the hospital which insists that it is financially advantageous to operate a school of nursing, I will only say that either they are not conducting an educational program in the best interests of the students, or the individuals making their financial studies are not providing them with proper information, or their situation may be a combination of both.[845]

It seems that Pickering took the opportunity to criticize those opposed to change in nursing education. Although the medical profession was not identified it is evident that as a group physicians were perturbed by the increasing autonomy of nursing. It appears that the physicians of the EGH were divided on the issue of nursing education. Dr. Moreau was obviously in agreement with the new trends and it is likely that others shared his views. However, there is evidence that some were not enthused about the changes which occurred.

On August 2, 1967, the minutes of the medical executive meeting reported: "It is felt that the medical executive should have some look at the teaching program that is being employed and used presently in teaching the nursing students."[846] The following December, Dr. Clare the medical director wrote in his annual report: "We in the

---

[844] ASGME, EGH, School of Nursing file, G.L. Pickering, Keynote address to graduating nurses, 19 August 1973.

[845] Ibid.

[846] ASGME, EGH, MMEM, 2 August 1967.

Edmonton General have long enjoyed one of the highest standards of nursing care, but of late there has been concern that the medical profession was being less and less involved or consulted concerning nursing education and planning of the curricula."[847] Based on these statements, it is apparent that there were some dissatisfaction among the medical staff.

It is believed that the events surrounding the advisability of providing an ICU (intensive care unit) rotation to nursing students best describe the different visions of what was considered to be sound nursing education. On August 7, 1967, Dr. Clare pointed out that there was a real problem of staffing in the ICU and that new graduates were afraid to work in the area. For him this fear was due to the fact that students were not exposed to this unit during their nursing diploma program.[848] A year later students still did not have a rotation in that department and it was stated in the minutes of the ICU committee that "Sister Leclerc believes this would demand specialized training which is not being offered during the basic course."[849] On September 4, 1968, the medical executive committee informed Mr. Pickering that they were disturbed by the absence of an ICU rotation and by the fact that they had not been consulted about the matter.[850] The school stood firm on the issue and a year later the annual report of the ICU committee still included a statement deploring the fact that nursing students still did not have an ICU rotation even if the physicians had recommended that such experience be introduced in the diploma program.[851]

Divergent views about what should be considered basic preparation were at the heart of the ICU question as well as the level of involvement of physicians in nursing curriculum. It may be suggested that some physicians believed that the absence of an

---

[847] Ibid., 20 December 1967.

[848] ASGME, EGH, MMSM, 7 August 1967.

[849] ASGME, EGH, MMSM, ICU Committee, 13 June 1968.

[850] ASGME, EGH, MMEM, 4 September 1968.

[851] Ibid., Annual report, December 1969.

ICU rotation was an indicator that clinical practice was being devalued at the expense of theoretical knowledge. The fact that they were consulted on curriculum matters less often than in the past also certainly must have conditioned their reactions to the changes in nursing education. In particular, many physicians of that era failed to understand that the provision of a general education was as important for patient care as clinical courses. It may also be suggested that they ventilated their frustration by telling those who were willing to listen that two-year nursing diploma programs offered insufficient clinical experience. A progress report submitted by Sister Leclerc to the EGH administration shows that the myth of the absence of appropriate clinical experience in a two-year program was indeed alive. Sister Leclerc wrote: "The second year students have received 75 hours of clinical practice in obstetric and the same number of hours in pediatrics during the month of November and 16 hours in class during the same period. These facts are recognized for the purpose of reassuring the persons who think that the two-year program students do not have sufficient practice in the hospital."[852] Another statement in Mr. Pickering's convocation address of 1973 further illustrates the divergent views which existed about nursing education. He said:

> We concluded there was a greater than ever before need to broaden the intellectual horizon of the student through greater exposure to the humanities and social sciences, and that this could best be done in a college setting. Despite all the current emphasis on specialization there is a great need for all professional persons to have a broader outlook on life including cultural development and not be merely high-class technicians. Statements made by over-zealous advocates of a work-oriented society notwithstanding, there is merit in learning for learning's sake simply because learning generally improves the person from both a social and individual standpoint.[853]

---

[852] ASGME, EGH, School of Nursing file, Progress report submitted by Sister Leclerc to the EGH board of directors, 1 December 1969.

[853] ASGME, EGH, School of Nursing file, G.L. Pickering, Keynote Address to graduating nurses, 19 August 1973.

Even if this statement was not made in relation to the ICU saga, it is evident that it was made to further affirm the position which had been taken by the Grey Nuns and the EGH School of Nursing in their pursuit of a leadership role in nursing education.

In conclusion, it is apparent that over its history the EGH School of Nursing fulfilled a province-wide role since it attracted students from every region of Alberta. Further, in most classes there were also students from Saskatchewan, most of whom came from regions close to Alberta. In general, there were a significant number of students from Edmonton who enrolled in the program. However, it was found that in the early 1930's the intake of students who were city residents was much lower than usual. It was suggested that the decline in the number of Edmonton students was probably linked to the fact that potential students from the city were more aware of some of the factors which made the school less attractive at the time. Graduation lists also revealed that, as expected, Franco-Albertans were inclined to select the EGH, and that in contrast to other cultural groups, their numbers did not decrease during the years of affiliation with *Collège Saint-Jean*. It is not possible to know what would have happened if the EGH School had continued to be linked with that institution. However, it is believed that if the Franco-Albertan community had not lost the right to French schools in the early 1900's, the situation would have been much different and the possibility of establishing a French nursing program would have likely been considered a priority by the ACFA. It is possible to suggest this, since the 1990's are bringing autonomous French school boards and the provincial association is now able to refocus its energy to other needs of the community, thus the provision of health care services in the French language is beginning to be systematically discussed.

Data on work schedules, attrition rates, curriculum and the faculty showed that the EGH school shared common characteristics with other Canadian schools. Although it is apparent that nursing students were considered part of the nursing workforce, data suggests that the sisters wished to provide them with a good education and that as early as 1917 they had articulated a vision about how to achieve this goal. However, the results of this study suggest that after the official separation of nursing education from nursing service in 1955, it became more feasible to give priority to the educational needs of the students. The subsequent adoption of a master rotation, of a nursing framework and the hiring of many new faculty members were concrete indicators of the benefits that came from the greater autonomy resulting from this separation. The establishment of the two-year program definitely ended the practice of considering students as workers, and significantly it reflected the view that the goal of diploma education was to prepare generalists who upon graduation could function in first level nursing positions. Specialization was thus considered within the realm of post-diploma preparation.

As a Catholic school of nursing the EGH School provided an environment in which Catholic values could be integrated. From a nursing point of view, it appears that the holistic philosophy of the sisters was advantageous in that it facilitated the integration of the notion that nurses must consider individuals/families as complex human beings who are more than biological entities. It can also be suggested that the fact that the school belonged to a network of Grey Nuns' schools and other Catholic schools. This was a strength since, from early on, faculty members had a network of colleagues with whom they could share ideas and discuss issues. It is believed that being part of such a network largely explains why the EGH did not fall behind and tended to be progressive in its educational policies. The closure of the school was probably a sad moment for some of the sisters who had contributed so much of their time and expertise to its development. However, this decision showed that the sisters understood that time had come to relinquish the old system of nursing education and move to a new and more educationally sound pattern.

CHAPTER 14

RESPONDING TO THE HEALTH CARE NEEDS OF THE POPULATION.

The purpose of this chapter is to examine patient care at the EGH and to provide evidence of the manner in which the hospital responded to the health care needs of the population. Finding data on these topics was much more difficult than anticipated. In particular, archival records included a limited number of statements directly related to patient care delivery. The unavailability of patient care records constituted a serious limitation. Such records could potentially have provided useful data about the evolution of nursing and medical care at the EGH.[854] Nevertheless, the available data provided some useful material by which it was possible to examine questions of interest.

As a general introduction, an overview of the health care policies of the three political parties holding power in the province between 1905 and 1970 is presented. The inclusion of a discussion about the health policies of each party is relevant because government policies had to be considered when planning to offer new services or to adjust services which where already in place at the hospital. For example, it has been suggested that if the sisters had not capitalized on the implementation of the Provincial Tuberculosis Act of 1936, the EGH may not have survived. The primary focus of this chapter is the study of patient care at the EGH. Statistics on the patient population and treatments are presented and analyzed. The hospital's response in times of epidemics is examined. Also discussed is the increasing level of specialization which characterized the post World War II era and led to the creation of a number of special care units and services. Finally, evidence suggesting the type of relationship which existed between medicine and nursing is presented. Available data about specific nursing care and nursing delivery systems is integrated throughout the chapter.

Government health care policies

Three political parties dominated Alberta politics between 1905 and 1970. The longevity of each of these parties was remarkably similar. All three held a number of consecutive mandates which were followed by important defeats and almost immediate oblivion. This should not be interpreted as meaning that political ideologies died with the electoral dismissal of parties. On the contrary, the political culture of Alberta is marked by continuity and the regular resurgence of key political themes. The Liberal Party reigned supreme from 1905 until 1921 when they were defeated by the United Farmers Association (UFA) which governed for the next fourteen years (1921-1935). In turn, the UFA was succeeded by the Social Credit Party which retained in power from 1935 until 1971.[855]

---

[854] However, it must be acknowledged, that accessibility of patient charts may have had limited value in respect of the history of nursing, since in most cases nurses' notes are not preserved when charts are transferred onto microfilm.

The Liberal Party, 1905-1921

The liberals won the first provincial election and thus formed the first government of the province. As stated previously their victory was in large part due to the geographical boundaries which had been drawn in Ottawa by the Laurier Liberal government. During their first decade in power, the liberals essentially relied upon the skeleton of health programs and policies which had been established by the Territorial Assembly. However, during their last years of governance they adopted a series of innovative measures. Among these were The Registered Nurse Act and The Public Health Nursing Act adopted in 1916 and 1919 respectively. In 1919, the government also created a ministry of health to which was transferred the already extant department of public health. Alberta was the second Canadian province to establish a ministry of health.[856] The Public Health Nurses Act was of great importance for the nursing profession because it stipulated that public health nurses required additional preparation to practice and that provision would be made to offer relevant courses at the University of Alberta.[857] However, it is essential to acknowledge that after WWI, there were a worldwide public health movement spearheaded in large part by the newly created

---

[855] In 1971, the Social Credit was defeated by the Progressive Conservative which still forms the government in 1994.

[856] Irene Stewart, ***These were our yesterdays, A history of district nursing in Alberta***, 2d ed., (Calgary: Friesen Printers, 1982), 9.

[857] Government of Alberta. "The Public Health Nurses Act", ***Statutes of Alberta***, (Edmonton: Queen's Printer, 1919), Article 37, 68.

League of Red Cross Societies, and that part of the efforts the Canadian Red Cross Society were directed at providing funding for post-diploma instruction in public health nursing. Importantly, the University of Alberta was one of five Canadian universities which received Red Cross funding used to offer nursing education programs.[858] Thus, it may be said that the Red Cross and the Alberta Public Health Nurses Act played a crucial role in the establishment of university nursing education in the province. The Act was also of primary importance because it recognized that nurses could play an important role in the area of prevention. The new policy did have a direct impact on the population since it led to the organization of preventive nursing care services in urban and rural areas. In particular, nurses began to inspect schools and to offer services in areas of the province which until then had hardly received any professional services. Of importance, *Travelling Child Welfare Clinics* were initiated in 1921 and public health nurses began to spend their summer months visiting children from remote areas and delivering health lectures to the local populations.[859]

A number of factors were part of the context which led to the establishment of the new health policies implemented by the liberal government. Importantly, the return of World War I veterans and the health crisis created by the Spanish influenza (1918-1919) made the population and government more aware of the necessity of providing adequate health services.[860] However, "... the pressures exerted by the United Farmers of Alberta on the party in power increased, [...] and explains the flood of innovating legislation that poured out of Edmonton during every war time session."[861] In respect of health care reforms, it was the United Farm Women Association (UFWA) which pressured the government to innovate. Proposals to establish a separate department of public health and to create a public health nursing program both emanated from the UFWA which has been described as the "social conscience of the farmers' movement".[862]

---

[858] Until the Red Cross initiative, the University of British Columbia was the only Canadian university offering nursing education. Red Cross funds were received by the Universities of Toronto, McGill, British Columbia, Alberta and Dalhousie. Janet Ross Kerr, "Financing University nursing education in Canada: 1919-1976," (Ph.D. diss., The University of Michigan, 1978), 48-49.

[859] Stewart, ***These were our yesterdays***, 11.

[860] Paul Victor Collins, "The public health policies of the United Farmers of Alberta government, 1921-1935." (M.A. thesis, University of Western Ontario, 1969), 4-5; Howard Palmer and Tamara Palmer, ***A new history of Alberta***, (Edmonton: Hurtig Publishers, 1991), 188.

The United Farmers of Alberta, 1921-1935

The context which led to the emergence of the UFA needs to be considered in order to understand how the Association successfully pressured the liberal government and was then transformed from a lobby group into a political party which took power in 1921. It is essential to first recall the motives which led to the creation of the province. As stated earlier, the residents of contemporary Alberta and Saskatchewan sought provincial status because they believed that such change would give them more control over questions affecting their lives. Being able to exert more control over wheat prices and tariff regulations in general, and obtaining accessible railway services were the key demands of the predominantly rural population of the prairies. Tariff policies were a particularly strong irritant for farmers who had to buy goods manufactured in eastern Canada and protected by a national market, while they had to sell their products on an open international market. Even if gains had been made by the establishment of federal policies such as the Crow's Nest Pass Agreement of 1897,[863] prairie residents believed that gains were not sufficient and that only provincial status would enable them to obtain better federal grants and success in the quest for revisions of the subsidy system.[864]

---

[861] Lewis G. Thomas, ***The liberal party in Alberta. A history of politics in the province of Alberta 1905-1921***, (Toronto: University of Toronto Press, 1959), 156.

[862] Collins, "The public health policies", iii-v.

[863] Through this agreement, the Canadian Pacific Railway (CPR) received public subsidies to build a railway line between Lethbridge (Alberta) and Nelson (British Columbia) via the Crow's Nest mountain pass. In exchange the Liberal government of Ottawa demanded that the CPR provide freight rate reductions on grain moving east and farm machineries moving westward. J.E. Conway, ***The West. The history of a region in confederation***, (Toronto: James Lorimer and Company Publishers, 1984), 47; Palmer and Palmer, ***Alberta a new history***, 51.

Finding ways to pressure the federal government led to the creation of farmers' associations which continued to flourish after the creation of Saskatchewan and Alberta. In 1909 in Alberta, the local associations decided to join their efforts in one large provincial association, the United Farmers of Alberta.[865] Although the provincial liberal government had generally been sympathetic to the farmers' demands, Ottawa continued to make few concessions and the farmers increasingly believed that the provincial liberals could not solve their problems.[866] Specifically, the rural population began to believe that the provincial liberals were too close in ideology to the federal liberals to be able to efficiently pressure the central government.[867] Discontent peaked soon after WWI when most farmers found themselves less well off than they had been prior to the conflict. Wheat prices had increased during the war, but they had not kept pace with the cost of operating a farm. Consequently, many farmers had borrowed money to survive and the high interest rates of the period had contributed to an even greater level of indebtedness. Thus, many felt at the mercy of Canadian banks whose head offices were all in eastern Canada.[868] "Farmers claimed with considerable justice, that the Canadian banking system had been created in eastern Canada for a commercial economy. The transposition of this system to a frontier agricultural economy worked a

---

[864] Conway, ***The west***, 43-51; Palmer and Palmer, ***Alberta a new history***, 128-129; Gerald Friesen, ***The Canadian Prairies A history***, (Toronto: University of Toronto Press, 1987), 238-239.

[865] Conway, Ibid., 49; Palmer and Palmer, ***Alberta a new history***, 151.

[866] Palmer and Palmer, Ibid., 152.

[867] C.B. Macpherson, ***Democracy in Alberta: Social Credit and the party system***, (Toronto: University of Toronto Press, 1962), 20.

[868] William Kirby Rolph, ***Henry Wise Wood of Alberta***, (Toronto: University of Toronto Press, 1950), 36.

hardship on producers and retarded the development of the country."[869] Based on these views, farmers concluded that the hegemony of the east on traditional political parties and on the banking system put them in a no-win situation. Therefore, it is not surprising that the ideology of cooperation which was proposed by prominent leaders of the association increasingly gained support as did the view that political reform was required.[870] Another consequence of this thinking was that a large segment of the UFA membership decided to embark on direct involvement in politics and to present candidates in the provincial election. Needless to say the UFA successfully dislodged the liberals at the 1921 election.

Once in power, the UFA refined the public health measures which had been taken by the previous government. Child welfare clinics were established in the large urban centres[871] and the number of rural district nursing stations was increased.[872] In addition, medical, nursing and dental traveling clinics were organized. Under this system district nurses screened children and established lists of those who needed medical care. The clinics were usually set up for two days in a given location; physical and dental examinations were done on the first day while surgery took place on the second day.[873]

Of interest, in 1932 the UFA government adopted a resolution to establish a provincial hospital insurance plan. Three years later, the legislature approved a health insurance bill under which the population would have been provided with a number of insured services.[874] One has to wonder why the UFA did not attempt to pass such legislation in its first mandate. It has been suggested that the economic difficulties of the 1920's and 1930's forced the party to be more conservative than anticipated. However, it is also believed that the fear of too much government control was an important deterrent factor. "There was a basic dichotomy in the outlook of the UFA administration between a humanitarian spirit, and a deeply-felt fear of government interference into the life of the individual."[875] Evidence also suggests that the fear of government intervention was not unique to Alberta. As early as 1919, the federal liberal government of Mackenzie King had entertained the idea of establishing a national health insurance program and broad opposition had resulted in the elimination of the project.[876] It is thus possible that the federal experience may have incited the UFA to postpone major health care reforms.

---

[869] Paul Sharp. ***The agrarian revolt in Western Canada. A survey showing American parallels***. (Minneapolis: University of Minnesota Press, 1948), 113.

[870] Rolph, ***Henry Wise Wood***, 65; Sharp, ***The agrarian revolt***, 189.

[871] Collins, "The public health policies ", 29.

[872] Stewart, ***These were our yesterdays***, 11.

[873] Ibid., 34; Herbert C. Jamieson, ***Early medicine in Alberta. The first seventy-five years***. (Edmonton: The Douglas Printing Company Limited, 1947), 79.

The Social Credit Party, 1935-1971

The circumstances which led to the victory of the Social Credit Party resembled those that had brought the UFA to power in 1921. In particular, the state of the economy and a sense of alienation perceived by Albertans played important roles in the rise of the new political party. The economic depression had caused much hardship. The rates of unemployment were high in the cities and the farmers who had not been forced off their land were debt ridden. Once again, Albertans expressed the view that eastern Canadians controlled the economy at the expense of the westerners. Their sense of alienation was based on the same claims that had been made in the early 1920's: the east had too much political power and bank and railways company head offices were all located in that part of the country. In concrete terms for them, it meant that easterners were setting wheat prices, loan rates, freight costs, tariff policies and, perhaps more important, that they monopolized industry.[877]

---

[874] Bow, "The history of the department of public health of Alberta." ***Canadian Journal of Public Health***, 26 (August 1935): 396; C. Howard Shillington, ***The road to medicare***, (Toronto: Del Graphics Publishing Department, 1972), 39-40; However, the legislation was never enacted because the Social Credit party which won the 1935 election shelved the bill and finally repealed it in 1942. Ibid., 40.

[875] Collins, "The public health policies", 136.

[876] George M. Torrance, "Social historical overview: The development of the Canadian health system." In ***Health and Canadian society, sociological perspectives***, 2d ed., ed. D, Coburn, C. D'Arcy, G. Torrance, and P. New, (Markham, Ontario: Fitzhenry and Whiteside, 1987), 17.

The need for reform found a champion in the person of William Aberhart who endorsed the economic theories of Major Douglas. His theories were based on the belief that depressions were due to a shortage of purchasing power, "...that the shortage was intentional on the part of power behind the banking system; and that the socialists could not be trusted to remedy the true evil of the financial apparatus."[878] Aberhart who was a teacher and a charismatic preacher possessed the right attributes to convince Albertans of the veracity of social credit theories. Significantly, because he had used the radio waves as a preaching medium, Aberhart was well known even before he began to talk about the social credit system. Using the radio as a political tool was certainly revolutionary at the time and it gave him an edge over traditional politicians. This means of communication was effective and by 1934 significant numbers of UFA supporters were turning to the emerging party.[879] One year later, the Social Credit Party decisively won the election.[880]

It is not amazing that a party which promised the end of unemployment, just prices, reform of the banking system and dividends of $25.00 a month for each citizen was appealing to the electorate. The economic depression had been so devastating that any one promising such changes would have probably won the election. In addition, the shift of the UFA membership to the Social Credit Party was understandable because both parties were concerned about similar issues and the latter proposed to accomplish what the former had not been able to accomplish. Both parties wished to rebel against the same oligarchic tendencies and both made similar assumptions about the nature of society.[881] In particular, they proposed that democracy would not survive unless humanity replaced money as the motivating force in human behaviour.[882]

---

[877] Richard F. Swann, "Progressive social credit in Alberta, 1935-1940." (Ph.D. diss., University of Cincinnati, 1971), 110.

[878] Ibid., 14.

[879] Social credit support was increasing so significantly that in 1934, the UFA government established a committee whose mission was to examine the Douglas proposals. Importantly, Douglas and Aberhart were invited to speak at the legislature. This move was likely an attempt to convince Albertans that Aberhart did not understand the social credit theory. John, A. Irving, ***The social credit movement in Alberta***, (Toronto: University of Toronto Press, 1959), 56; Palmer and Palmer, ***Alberta a new history***, 259.

[880] Fifty-six of the 63 seats of the legislature went to the Social Credit Party. Palmer and Palmer, Ibid., 267.

In assessing the differences between the two parties, it was noted that while the UFA had traditionally drawn most of its members from rural areas, Social Credit had a broader appeal since it also attracted members of the labour movement and of the urban working classes.[883] Another difference between the two parties was that the social credit party attracted people for religious reasons. Aberhart's fundamentalist religious beliefs were appealing to many Albertans who shared similar views. Interestingly, many devout Roman Catholics were not repelled by the religious tone of the party leader's statements. Some such as Lucien Maynard[884] believed that the social credit principles were implicit in some Papal encyclicals, notably in *Rerum Novarum* and *Quadrasegismo Anno*.[885] Incidently, it has been proposed that the victory of Maynard in a predominantly French Canadian and Roman Catholic riding was linked to a campaign strategy in which he constantly showed the links between the social credit philosophy and these encyclicals.[886]

---

[881] Macpherson, ***Democracy in Alberta***, 3.

[882] Irving, ***The social credit movement***, 231.

[883] Ibid., 232.

[884] Maynard was a Franco-Albertan lawyer who belonged to the Roman Catholic Church. He was elected in 1935, in the Beaver River riding (St. Paul's area).

[885] A discussion about these encyclical is included on the chapter devoted to the EGH work force.

It is believed that Aberhart's interest in social justice probably explains the concern he showed about health care issues and the fact that his government adopted a number of new health care policies. The words of a nurse tells much about the appeal the social credit may have had on some members of the profession:

> As a nurse, I have always been worried about the economic system. In childbirth, for example, all women go through exactly the same experience, whether they are rich or poor. But the care a woman commands in childbirth depends upon her economic status. The rich woman commands attention, the doctors flutter around her. But the poor woman is put into a different type of bed and ward. I have observed too, that the poor woman often has a mental anguish about the economic future of her child ... From my experience as a nurse, I had felt the urge to help people get financial security. This urge boiled in me during the depression. We had big production here without the possibility of consumption owing to no buying power. [...] I started to work hard for the Social Credit. Not any opposing political party, but the whole existing monetary system was our opponent.[887]

Once in power, Aberhart did not implement universal health insurance coverage. However a series of pieces of legislation increased accessibility particularly in the field of hospital services. The province passed a tuberculosis act in 1936, a poliomyelitis act in 1938, and a cancer treatment and prevention act in 1940, the latter leading to the opening of two cancer clinics.[888] Of importance, these acts were the first in the province which were concerned with diseases predominantly treated in hospitals or institutions. Although these new pieces of legislation had implications for public health services they also had direct consequences for hospital services. The common trait of all of them was that they ensured free hospital and diagnostic services for those who were affected by these diseases.

---

[886] Irving, ***The social credit movement***, 216. It is interesting to note that Quebec was the only other province where the social credit eventually found a significant number of supporters. Significantly, some of the politicians of that province used the same strategies that had been employed by Maynard to convince the electorate.

[887] Ibid., 245-246. This nurse had been interviewed by Irving.

[888] Jamieson, ***Early medicine in Alberta***, 81-82; Shillington, ***The road to medicare***, 40; and Swan, "Progressive Social Credit", 212-213.

Following the death of Aberhart in 1943, Ernest Manning was elected to replace him and served as Premier of the province for the next twenty-five years. A piecemeal approach continued to characterize Alberta's health care policy making. In 1944 the province adopted legislation which provided hospitalization coverage for new mothers and their infants, and in 1947 the legislature adopted an act by which the hospitalization costs of old age pensioners were covered.[889] It is difficult to know Aberhart's response to the health care reform proposals which emerged from the federal government after World War II would have been. It is known, however, that Manning did not favour national medicare policies.[890]

It seems reasonable to conclude that under Manning, the Social Credit Party became increasingly right wing. "His philosophy of individualism, strong opposition to socialism, Cold War rhetoric, and anti-unionism appealed to the businessmen."[891] The Manning government was willing to offer services to the disadvantaged individuals but it was opposed to universal and compulsory hospital and medical coverage. In 1961, J. Donavan Ross, who was then minister of health, expressed the view that such a system would remove all direct individual financial responsibility and that it was incompatible with the rights and responsibilities inherent in a free democratic society.[892] It is thus not surprising that in the name of individualism and provincial autonomy, Alberta opposed the universal measures proposed by the federal government during the 1950's and 1960's. It may be suggested that one of the strategies used by the province in trying to curtail federal ambitions was to continue to add programs which enabled legislators to argue that the citizens of the province were already well served. For example, by the mid-fifties the province had so much special legislation directed at specific groups that it could assert that those in need were not neglected. Their conclusion was therefore that federal hospital insurance policies were not needed. Similarly in 1963, the province in collaboration with the medical profession established a medical insurance plan. Under this plan, Alberta covered the medical services provided to the indigent, and established a set of standards for private insurance coverage for those who could afford to pay for services.[893] However, once federal legislation was passed in 1957 (The Hospital Insurance and Diagnostic Services Act) and in 1967 (The Medical Care Act), the province could not afford to remain outside the plans because monetary returns from Ottawa were to important to be ignored. In addition, it is unlikely that Albertans would have accepted being left out of the new national system.

---

[889] Jamieson, ***Early medicine in Alberta***, 82 and 86.

[890] Palmer and Palmer, ***Alberta a new history***, 716; Malcom G. Taylor, ***Health insurance and Canadian public policy. The seven decisions that created the Canadian health insurance system***, (Montreal: McGill-Queen's University Press), 337-360.

[891] Palmer and Palmer, ***Alberta a new history***, 314.

[892] Taylor, ***Health insurance and Canadian public policy***, 338.

This general overview shows that until the adoption of national federal policies, the three political parties which governed Alberta passed a series of legislative acts which gradually increased the involvement of the province in health care policy making and delivery. It may also be suggested that there was a link between the focus of health legislation and the role played by the hospital in society. When the Liberals and the United Farmers were in power, most policies centered on public health issues and services which were not predominantly given in hospitals. These policies were well suited for a time when curative measures and medical technology were rudimentary and when the hospital was still used by a relatively small proportion of the population. Logically, legislation related to hospital and medical care coverage began to be implemented once the hospital had become a health factory, that is, when curative medicine was sufficiently developed to give the illusion that it would eventually solve all ailments affecting humankind. It is thus not surprising that the health legislation of the Social Creditors was different from that of their predecessors. Like the rest of society, the governments of the post WWII era were mesmerized by the discoveries of modern medical science. The hospital had become the essential tool by which this science could be put to use and consequently the legislators put their energy towards the creation of hospital and medical care insurance programs. The desire to develop such programs was commendable and necessary. However, it is believed that there was a fundamental problem in the approach taken by the governments of the time. The change of focus was such that they took few initiatives in the areas of public health and prevention. Believing that all would be solved by curative medicine was naive and even detrimental as it may be suggested that the health care funding difficulties of the 1990's are the direct consequences of this blind faith in curative medicine.

---

[893] Shillington, ***The road to medicare***, 123.

Patient care statistics

The hospital annual reports and the minutes of the medical staff meetings provided statistics about patient care between 1913 and 1967. Although not always available for each of these 55 years, records were found providing information on the number of admissions, the number of surgical admissions, the number of deaths, the number of tuberculosis admissions, the number of patients who died from that disease, the number of deliveries and the number of X-Rays and laboratory tests performed on a yearly basis. The fact that these statistics were general in nature and not consistently recorded for each of the above topics constitutes a limitation. Nevertheless, the available data gives a general overview of the changes which took place at the EGH between 1913 and 1967. Further, it may be proposed that variability in what is found may be an indicator of the evolution of the institution.

Admissions between 1913 and 1967

The annual reports of 1913 until 1967 provided statistics on the number of patients who were admitted to the EGH as well as the number of surgical admissions.[894] Subtracting the number of surgical admissions from total admissions yielded the number of patients who were admitted for other reasons than surgery. Results presented in Table 84 show the variation in the number and percentage of surgical and non-surgical admissions over time. It is strikingly apparent that the number of surgical admissions greatly decreased during the period of time from 1936 to 1952 when a large number of beds were used for the treatment of tuberculosis. The gradual decline in the number of surgical admissions prior to that era was probably linked to the increasing diversity of services being offered at the hospital including obstetrical care which had become important in the 1920's. Understandably, after the closure of the tuberculosis departments in the early 1950's, the percentage of surgical admissions began to increase and returned to the levels found between 1913 and 1920. The hospital has thus returned to its original mission.

---

[894] ASGME, EGH, Annual reports, 1913 to 1967.

TABLE 84

ADMISSION STATISTICS BETWEEN 1913 AND 1967[895]

Period of time	n of surgical admissions (%)	n of medical admissions (%)	total n of admissions
1913-14 to 1919-20	8,892 (61.41)	5,587 (38.59)	14,479
1920-21 to 1924-25	5,800 (47.92)	6,304 (52.08)	12,104
1925-26 to 1929-30	8,592 (46.16)	10,442 (53.84)	19,394
1930-31 to 1934-35	6,881 (46.35)	7,965 (53.65)	14,846
1935-36 to 1939-40	6,571 (41.61)	9,221 (58.39)	15,792
1940-41 to 1944	6,767 (30.04)	15,756 (69.96)	22,523
1945 to 1949	16,473 (45.55)	19,695 (54.45)	36,168
1950 to 1954	28,160 (53.43)	24,545 (46.57)	52,705
1955 to 1959	34,310 (51.40)	32,439 (48.60)	66,749
1960 to 1967	62,522 (60.61)	40,637 (39.39)	103,159

---

[895] Ibid. Data was not available for 1914-1915 and 1921-1922.

TABLE 85

NUMBER OF DEATHS AND PERCENTAGE OF DEATHS BASED ON THE NUMBER OF ADMISSIONS BY TIME PERIOD[896]

Period of time	n of deaths	% of deaths
1913-14 to 1919-20	456	3.15
1920-21 to 1924-25	380	3.14
1925-26 to 1929-30	563	2.90
1930-31 to 1934-35	462	3.11
1935-36 to 1939-40	460	2.91
1940-41 to 1944	606	2.69
1945 to 1949	995	2.75
1950 to 1954	1025	1.94
1955 to 1959	985	1.48
1960 to 1967	1890	1.83

Deaths between 1913 and 1967

Results presented in Table 85 show that the percentage of patients who died while at the EGH declined over time. Although the difference between the percentages of the 1910's and of the 1960's is small, it may be suggested that the variation may have been clinically significant. It is difficult to determine why the percentage of deaths fell to under 2% after 1950. A multitude of factors for which data was not unavailable would need to be considered. However, one has to wonder if the proliferation of new antibiotics and the greater usage of blood transfusions after WWII were not key factors that contributed to this overall decrease in the percentage of deaths. Available data about the number of antibiotic prescriptions show the extent to which these drugs were widely used at the EGH. Statistics for 1953 and 1954 are quite revealing. In 1953, 10,991 patients were admitted to the EGH and 59,374 prescriptions were filled.

---

[896] ASGME, EGH, Annual report, 1913 to 1967.

However, it was stated in the annual report that these statistics did not include antibiotic prescriptions. In contrast, in 1954 antibiotics were included in the reported number of prescriptions. That year, 12,141 patients were admitted and 98,323 prescriptions were filled. Although this data did not reveal the number of antibiotic preparations, it is evident that since there were only 1,150 additional patients a large proportion of the extra 38,949 prescriptions must have been antibiotic orders. The likelihood of this supposition is even greater when examining the data of 1956 and 1957. In 1956, antibiotics were included in the number of prescriptions. The annual report of that year stated that 12,817 patients had been admitted and that 91,259 prescriptions had been filled. In the following year, the report did not include antibiotics and only 59,249 prescriptions were given to 13,523 patients.[897]

Tuberculosis statistics

At least 1,750 patients who had tuberculosis were admitted to the EGH between 1936 and 1951.[898] Statistics presented in Table 86 show the number of tuberculosis admissions, and the number and percentage of patients who died from the disease during those years. These results show that mortality was almost always above 15% between 1937 and 1948 and that after that year it was never greater than 10.93%.[899]

---

[897] ASGME, EGH, Annual reports, 1953, 1954, 1956 and 1957.

[898] Data on the number of tuberculosis admissions was unavailable between 1943 and 1947.

[899] The factors which may have contributed to a reduction of mortality rates are addressed elsewhere.

TABLE 86

TUBERCULOSIS STATISTICS[900]

Year	n of tuberculosis admissions	n of tuberculosis deaths	% of tuberculosis deaths
1936-37	83+	?*	?*
1937-38	74	16	21.62
1938-39	90	30	33.33
1939-40	143	24	16.78
1941	205	36	17.56
1942	184	24	13.04
1948	224	34	15.17
1949	293	27	9.22
1950	262	20	7.63
1951	192	21	10.93
Total	1750+	232+	13.26

* Data not available

Examining the percentage of hospital deaths which were due to tuberculosis reveals the extent to which it was devastating. Between 1937-38 and 1942, 130 (25.4%) of the 511 patients who died at the EGH were tuberculosis admissions. The magnitude of tuberculosis deaths is even more evident in light of the fact that tuberculosis admissions comprised only 3.84% of the total number of admissions during that period of time. However, the situation significantly improved between 1948 and 1951. During these years, 102 patients died of tuberculosis while there were 761 deaths in patients who had been admitted for other diseases. Thus, only 11.8% of total deaths occurred in people who had tuberculosis. This smaller percentage is particularly significant when considering that the number of sanatorium beds had not decreased during that period of time.

---

[900] ASGME, EGH, Annual Reports, 1936-37 to 1942, 1948 to 1951.

Obstetrical statistics

The number of births began to be consistently recorded in the hospital annual reports in 1952. Of note is the fact that most tuberculosis patients had by then been transferred to the Aberhart Hospital. Their departure lead to the resurgence of a full fledged maternity service. Significantly, it appears that the hospital replaced one insured service with another insured service. In 1952, the EGH had 29 cribs while a year later the number had risen to 69.[901] Aside from financial considerations, it is likely that the baby boom was an important factor to the decision to increase the number of cribs. In 1952, 1066 babies were born at the EGH. By 1955 the number of births had risen to 2,456 and this number steadily increased until 1963 when 2,546 babies entered the world at the hospital. After that year, the numbers began to decline and the lowest number of births was seen in 1967 when only 2,150 children were born.

Number of X-Ray and laboratory tests over time

When the national hospital insurance program policies were adopted in 1958, many feared that there would be a grand rush to hospitals. However, Taylor noted that contrary to predictions, hospital admissions did not significantly increase.[902] Raw data on the number of admissions at the EGH show that in 1957 there were 13,253 admissions while in 1958, 14296 patients were admitted. There was thus 1,043 additional admissions the year that hospital insurance was established in Alberta. However, after 1958 and until 1967 the number of admissions was never lower than 12,292 (1962) and never higher than 13,365 (1966). The fact that the number of beds did not increase during these years certainly contributed to this stability and figures concerning the overall occupancy would have been necessary to draw firm conclusions. Yet, since the number of admissions did not significantly increase it may be suggested that patients did not seek admission to any greater extent than they had in the past.

---

[901] The number of cribs remained the same until 1967, last year for which data was available. ASGME, EGH, Annual reports, 1951 to 1967.

[902] Taylor, ***Health insurance and Canadian public policy***, 234.

Although, it may be proposed that the hospital insurance plan did not have a patient driven effect, it appears that it may have had physician driven consequences. The results presented in Table 87 show that the number of X-Rays rose from 1.43 per admission in 1956 to 4.21 in 1967. The fact that the proportion of surgical admissions increased during this period of time (see Table 84) may account for much of that difference. However, it is unlikely that the same justification can explain the spectacular rise in laboratory testing which was seen during those years. Indeed, in 1956, 18.37 tests were done on admission while by 1967 the number had reached 54.86 procedures per new patient. It is likely that a number of these examinations were not necessary and that if insurance plans had not existed that the number of laboratory procedures would not have risen with such speed.

As early as 1954, the administration showed concern about the rising numbers of laboratory tests. Importantly, there were already a number of tests that were covered by the state or other forms of insurance. On December 15, 1954, the hospital superior informed the physicians that the patient per diem costs had increased to $14.23 while the revenue was only $12.79. She stated that the rise in cost was in part due to the increased demand for laboratory tests. It is obvious that she believed that some unnecessary tests were being conducted. She wrote: "May we respectfully ask you to review your procedures to see if something might not be done to alleviate this serious situation without, of course, sacrificing standards of patient care?"[903]

---

[903] ASGME, EGH, MMSM, Letter of Sister Bézaire, Superior, to the physicians of the EGH, 15 December 1954.

TABLE 87

STATISTICS ON X-RAY AND LABORATORY EXAMINATIONS FOR SELECTED YEARS[904]

year	n of X-Rays	n of X-Rays per admissions	n of lab. tests	n of lab. tests per admissions
1938	2,700	0.90	13,380	4.48
1948	9,480	1.20	52,104	6.61
1952	10,402	1.05	75,596	7.64
1954	11,463	0.94	94,963	7.82
1956	18,360	1.43	235,423	18.37
1958	48,316	3.38	368,002	25.74
1960	51,215	3.81	429,067	31.91
1962	42,157	3.43	434,013	35.31
1964	45,404	3.60	499,062	39.55
1966	50,478	3.78	605,248	45.29
1967	56,062	4.21	730,715	54.86

It is evident that the superior's recommendations did not halt the trend towards higher numbers of laboratory procedures. However, in the 1960's, some physicians began to be concerned about the rising costs which resulted from this trend. In 1960, the medical executive committee noted that the volume of laboratory tests performed on the weekends had increased so much that the volume of work had almost doubled between 1957 and 1958 alone. Although the minutes did not provide more details about the content of the discussion it may be suggested that members of the executive considered that too many tests were being done since it was decided to include the topic on the agenda of the next general meeting.[905] Interestingly, in 1967, the medical executive committee made a clear statement in respect to that matter. The minutes stated: "Physicians need to contribute [to cost control measures] by not ordering unnecessary laboratory tests, medications and dressing changes."[906] Again, based on the laboratory statistics it is apparent that the administration and the medical executive committee failed to control the usage of laboratory services. Even if the increasing number of laboratory procedures might have been in part occasioned by changing standards, it seems reasonable to conclude that the source of the problem was to be found in the high level of autonomy of medical practitioners. If they had been employees like other workers, it is unlikely that they would have been able to continue to prescribe at the same rates as previously. As employees, they would have had to be more accountable for actions which contributed to rising costs.

---

[904] All results are based on Annual Reports except for the 1938 and 1948 data which was collected from the minutes of the medical meetings of these years.

Responding to epidemics and infectious diseases

For much of this century and particularly before WWII, the control of epidemics and of the transmission of infectious diseases in general constituted two of the most important challenges confronting health care professionals. It is thus not surprising that the hospital chronicles and to a lesser degree the minutes of the medical staff meetings regularly included statements about these health issues. It has already been shown that the EGH responded to the crisis occasioned by epidemics and that it offered services to patients afflicted by diseases such as tuberculosis and poliomyelitis. Thus, the purpose of this section is to more closely examine the statements which were made about epidemics and contagious diseases in order to better understand the involvement of the hospital in health care services delivery.

Smallpox

The smallpox epidemic of 1901 was the first epidemic mentioned in the EGH chronicles and other documents of the hospital. As already seen, Edmonton did not have an isolation hospital and the Grey Nuns offered to provide services in a house which had been rented from the Hudson's Bay Company. Sisters Beauchemin, Coursol, Georgianna and Adeline were sent to that temporary hospital and Dr. Roy volunteered his services for the sum of $25.00 a day. Apparently, the first five patients were a widow and her four children. When she regained her health, this widow remained on site to assist the sisters who had by then been joined by Miss Kennedy, a lay nurse of the Misericordia Hospital and Father Leduc. Services were offered from February 21 until May 20, 1901 and although the number of patients treated during the epidemic was not recorded, it is known that for a number of weeks as many as 45 patients were under the constant care of the Grey Nuns.[907] The care given must have been excellent considering that the sisters lost only one patient.

---

[905] ASGME, EGH, MMEM, 6 April 1960.

[906] Ibid., 6 September 1967.

The archival records did not provide details about patient care practices. However, contemporaneous nursing literature can be used to suggest the type of care which was likely offered to these patients. At the beginning of this century it was recommended that smallpox victims be kept in a cool environment, and that regular sponge baths be administered. The purpose of these measures was to reduce the fever of the disease. Proper hydration was also a priority and patients were fed a clear fluid diet. Skin care consisting mostly of vaseline applications also had to be regularly provided in order to avoid extension of affected areas. Finally, in order to avoid propagation of the disease it was customary to burn all soiled dressings.[908] This description shows that care was predominantly directed at lowering fever and keeping patients comfortable. Curative measures were limited and it may be stated that the provision of attentive nursing care was the chief measure employed to foster recovery and limit complications.

Spanish influenza

The Spanish influenza epidemic of 1918 was certainly one of the most devastating epidemics of this century. It has been estimated that in Edmonton alone 454 individuals died from the disease.[909] The disease spread quickly and the epidemic was of such proportions that the five hospitals of the city could not meet the demand for beds. Consequently, the local public health board elected to transform Pembina Hall at the University of Alberta into an emergency hospital. By the end of November 1918, at least 300 patients had been admitted at this location.[910] Significantly, school teachers were amongst the many who offered their services to assist health care professionals in the temporary hospital and in the homes of those who were affected. Roman Catholic organizations also took part in relief activities. In particular, the Ursulines, the Franciscan Sisters and the Knights of Columbus participated by delivering health care services and transportation for victims and their families.

---

[907] ASGME, EGH, Chroniques, 1901; Hôpital Edmonton visites canoniques 1896-1953, Visit of Mother Filiatrault 15 April 1901.

[908] Hampton, ***Nursing: Its principles and practice***, 448-450.

From the outset, the EGH was filled with influenza victims. At this time the hospital had less than 100 beds, but space was found for at least 150 patients by transforming every available space into patient care areas. It was stated in a document written in 1918 that:

> The nursing staff has been doing its bit with a smile and they have been very successful. Of the 192 patients admitted to date - and some were received in a critical condition - 10 died, 150 remain in different stages of convalescence and 32 have been discharged as permanently recovered. A patient stays on an average of ten days. A few nurses have contracted the disease, but none have been seriously ill.[911]

Although in Alberta influenza outbreaks have always been common in winter months, the death toll never reached the proportions found during the Spanish influenza epidemic. However, flare-ups were always taken seriously and special measures were taken to reduce the risks of contagion. For example, in January 1937, the Edmonton Board of

---

[909] MacGregor, ***Edmonton a history***, 224.

[910] Ibid.

[911] ASGME, EHH, Doc. 101, 1918. Probably written in December 1918.

Health asked the EGH to interrupt surgical activities for one week, and in February 1951, the administration eliminated visiting privileges for two weeks.[912]

Tuberculosis

As stated in a previous chapter, in 1932, the EGH administration proposed to the province that the hospital be permitted to transform a section into a specialized tuberculosis service. In a letter to the deputy minister of health, the Grey Nuns' provincial superior wrote:

> The executive of our institution came to the conclusion that since it is in line with the Legislature's plan to construct tubercular annexes to public hospitals and since the city of Edmonton has more than necessary accommodations and equipment for medical and surgical cases it would, perhaps, be well to submit to the authorities of the Health board of Alberta, the proposition of modifying the activities of the General Hospital to provide suitable hospitalization facilities for the treatment and care of tubercular patients.[913]

As the government could not afford to build, it does not seem that any tuberculosis annexes were constructed during those years of crisis. It is difficult to understand why the government did not accept the Grey Nuns' offer particularly since beds were needed and since appropriate space already existed at the hospital.[914]

However, four years later the new Social Credit government took proactive measures in the area of tuberculosis care. The EGH offer was reconsidered and from 1936 until 1952, the hospital became the most important provider of tuberculosis care in Edmonton. Significantly, because of the city's location, the EGH also became the treatment centre for the populations of Northern Alberta. It is reasonable to suggest that it was probably during the operation of the sanatorium that the EGH was the most involved in the care of patients who were not from Edmonton. In particular, the chronicles revealed that Native patients were among those treated on the tuberculosis units especially during the first years of operation.[915] Mention of native individuals were not as common after 1946 and it is likely that fewer natives were admitted after that year. Indeed, in 1946 the federal government opened the Charles Camsell Hospital whose mission was to provide sanatorium services to native and Inuit populations.[916]

---

[912] Privileges were maintained for the families of dying patients. ASGME, EGH, Chroniques, 24 January 1937 and 13 February 1951.

[913] ASGME, EGH, Département des tuberculeux 1932-1946, Doc. 1, Letter of Sister Laberge to Dr. M.R. Bow deputy minister of health, 1 March 1932.

[914] A letter of Dr. M.R. Bow stated that the government had rejected the offer. ASGME, EGH, Département des tuberculeux 1932-1946, Doc. 3, Letter of Dr. Bow to Sister Laberge, 19 April 1932.

For much of this century, tuberculosis has been a serious public health threat in Canada and Alberta. For example, Alberta mortality rates were 53.2/100,00 in 1921 and as high as 41.3/100,000 in 1941. However, by 1955 mortality rates had decreased to 7.4/100,000, and in 1970 they had reached 08./100,000.[917] Not surprisingly, these figures paralleled the percentage of tuberculosis deaths at the EGH (see Table 86). The importance of the disease is reflected in the fact that, between 1943 and 1954, more articles on this clinical topic were published in *The Canadian Nurse* than on any other.[918] The gradual decrease in the number of fatalities and in morbidity levels has been attributed to a number of factors among which are the public health efforts, the sanatorium movement, and the discoveries of the BCG vaccine and antibiotics which directly attacked the tubercle bacillus.

Public health efforts concentrated on preventive measures and isolation of those affected by the disease. The sanatorium movement was also part of the equation. Not only did sanatoria provide patient care, but they reduced the risk of disease propagation by isolating individuals from their families. The first North American sanatorium was opened in 1885 in the Adirondack Mountains (northeastern United States) by Drs. E.L. Trudeau and Alfred Loomis.[919] It must be noted that Europeans had long believed that alpine regions offered climatic conditions which could alter the course of the disease. Not surprisingly, a number of the first Canadian sanatoria were located in mountainous areas, including the first ones of Alberta.[920]

---

[915] ASGME, EGH, Chroniques, 1940, 1943 and 1944.

[916] This Edmonton hospital was initially located in the Jesuit College which had been sold to the Canadian Armed Forces during World War II. Elva Taylor, "Care of our Native Canadians," ***The Canadian Nurse***, 48 (February 1952): 123.

[917] George, Jasper Wherrett, ***The miracle of the empty beds: a history of tuberculosis in Canada***, (Toronto: University of Toronto Press, 1977), 253.

[918] During that period of time an average of 8 tuberculosis articles a year were printed in this nursing journal.

As for other infectious diseases, an important step towards eradication was reached in 1924 when Drs. Albert Calmette and Camille Guérin of the *Institut Louis Pasteur* discovered BCG vaccine. In 1933, Dr. Armand Frappier, a bacteriologist at the *Université de Montréal* who had studied at the *Institut*, introduced the vaccine to Canada. Under his leadership vaccine production was undertaken and Montreal became the national supplier of this new powerful tool.[921] After the discovery of this vaccine no major findings were made until 1944 when Dr. Selman Walksman and his associates discovered streptomycin which was the first antibiotic that directly affected the tubercle bacillus. However, the introduction of this new drug and others which were developed in the following two decades significantly contributed to the improvement of survival rates and to the decreased length of hospitalization.[922]

Little was learned from the records about the actual care given by nurses and physicians on the tuberculosis units of the EGH. Literature on the nursing care of patients with the disease indicates that in the 1930's rest, a balanced diet and fresh air were still considered key weapons against tuberculosis. Providing distraction was also considered an important aspect of the nursing care regimen.[923] The EGH chronicles revealed that the nursing staff regularly organized patient activities including movie presentations and parties. Evidence also indicates that children were provided with learning activities including reading and arithmetic tutorials.[924] Until the discovery of antibiotics that could significantly curtail the disease, it appears that patient care routines remained almost unchanged, except for the fact that surgical intervention was increasingly used to increase patients' chances of survival. Finally, it is important to mention that the involvement of the EGH in tuberculosis care was not restricted to in-patient treatment. It is accurate to state that the hospital directly contributed to the public health effort against the disease. For example, in 1943, the school children of Edmonton and St. Albert were all received at the hospital for screening tests.[925]

---

[919] After having been diagnosed with tuberculosis, Dr. Trudeau went to the mountains and, finding relief, decided to work towards the provision of a means by which other patients would benefit from the climate. Gibbon and Mathewson, ***Three centuries of Canadian nursing***, 431.

[920] During World War I, a hotel which had survived the landslide at Frank was used as a sanatorium for military personnel. After the war, the Keith Sanatorium was opened at Bowness (west of Calgary) in the foothill area of the Rocky Mountains.

[921] James H. Marsh, ed. ***The Canadian encyclopedia***, (Edmonton: Hurtig Publishers, 1985), s.v. "Armand Frappier," by Claude Vézina.

[922] Wherrett, ***The miracle of empty beds***, 17.

Poliomyelitis

In Canada, the early 1950's were characterized by annual outbreaks of poliomyelitis. Although the disease was not new, it was during the first years of this decade that the country experienced its largest epidemics. The worst occurred in 1953 when 8,878 cases were reported, 4,491 of which were found in the Prairie Provinces.[926] In Edmonton in the early 1950's, the RAH treated the patients who were in the acute and contagious stages of the disease, while the EGH and the University Hospitals received those who were no longer contagious. The official involvement of the EGH in the care of poliomyelitis patients began in October 1952 when upon request of the minister of health, the hospital administration agreed to keep 11 beds for the treatment of these patients.[927] Patients requiring massage treatments and physiotherapy began to be transferred from the RAH to the EGH and a second physiotherapist was immediately hired.[928] Edmonton was greatly affected by the epidemic of 1953 and the EGH chronicles revealed that in November of that year the Medical Association of Alberta requested that physicians volunteer to assist their colleagues at the RAH. Significantly, many physicians and nurses of the EGH heard the call and gave a hand to the RAH personnel.[929]

---

[923] Gibbon and Mathewson, ***Three centuries of Canadian nursing***, 483; Cashman, ***Heritage of service***, 285-286.

[924] ASGME, EGH, Chroniques, 1936 to 1951.

[925] ASGME, EGH, Chroniques, 11, 12 and 13 November 1943.

[926] Dominion Bureau of Statistics, ***Poliomyelitis trends***, (Ottawa: Queen's Printer, 1957), 15.

It has been estimated that between 1952 and 1957 the EGH treated at least 75 poliomyelitis patients, many of whom required the dreaded iron lungs.[930] Writing about the care given at the EGH, Taylor offered the following testimony:

> Polio survivors may remember the Alex with gratitude, but they remember St. Mary's [the EGH ward] with affection. This is partly because at the time the Edmonton General was still more a "private" then a "public" hospital, and medical and nursing volunteers were drawn from its own staff. But more importantly, it was due to the dedication of Sister Superior (Bernadette Bézaire) who came to the General in 1953 from Saskatoon where she had gained experience with respiratory patients, and also to the similar dedication of Lillian Hope, Charge Nurse on St. Mary's ward. Both of these nurses were deeply moved by the plight of polio patients and their dedication to the relief of the suffering was palpable.[931]

As had been the case for tuberculosis patients, recreational activities were organized for poliomyelitis patients. However, it seems that Edmontonians were more involved then they had been for tuberculosis patients. It must be recalled that the 1950's were definitely more prosperous than the two previous decades. The fact that many poliomyelitis sufferers were young individuals may also have contributed to the outbursts of solidarity, sympathy and generosity. The Canadian Legion donated a piano and volunteers prepared Christmas presents and, in 1954, the Eaton store brought two large trucks onto which all poliomyelitis patients were lifted in order for them to be able to see the provincial exposition parade. The same year, a private firm delivered television sets during the Canadian Football League finals enabling the poliomyelitis patients to witness the winning of the Grey Cup by the Edmonton Eskimos.[932]

---

[927] ASGME, EGH, Chroniques, October 1952.

[928] ASGME, EGH, Chronologie française, October 1952.

[929] ASGME, EGH, Chroniques, October 1953.

[930] After 1957 all poliomyelitis patients were transferred to the University Hospitals where a new wing had been built to accommodate their needs. Russell F. Taylor, ***A memorial for Russell Frederick Taylor, Polio' 53***, (Edmonton: University of Alberta Press, 1990), 24.

[931] Ibid.

Infection control

Limiting the propagation of infectious diseases and the spread of epidemics has long been a central preoccupation of health care workers. Quarantine and isolation were probably the first infection control measures used by hospitals and public health authorities. At the EGH, quarantine periods were instituted at least twice during the 1930's when a few cases of scarlet fever were diagnosed on children wards. The patients who had the disease were transferred to the isolation hospital while quarantine was observed for seven days and the wards completely disinfected.[933] However, as time passed and as medical science progressed, new regulations and infection control protocols were designed to combat contagious ailments. Protecting the workers also became a priority. For example, in 1956 all EGH staff who had worked with poliomyelitis patients received the new Salk vaccine.[934] It also appears that old methods which had been used "across the board" became more targeted. For example, during the 1953 poliomyelitis epidemic, only tonsillectomies were cancelled for months while in previous years, evidence suggests that all surgical interventions were cancelled.[935] It may be suggested that the increasing knowledge about mode of transmission of disease may have enabled public health authorities to be more selective in their approaches.

---

[932] ASGME, EGH, Chroniques, 1952 to 1957.

[933] Ibid., 7 November 1935, and 12 October 1936.

[934] Ibid., 12 May 1956.

It is evident that today's universal precautions[936] have their roots in systems that were designed earlier in this century. For example, some of the measures which were used at the Keith Sanatorium in 1935 continue to be utilized.[937] However, evidence suggests that infection control measures were primarily known and utilized by professionals who worked in specialized units or isolation hospitals. Events which occurred at the EGH in the 1950's and 1960's confirm this view and are corroborated by the CNA curriculum committee.[938]

In 1952, a joint medical-nursing committee was established at the EGH.[939] It is rather interesting that such committee was created immediately following the closure of the sanatorium service. Although it may have been coincidental, one wonders if the hospital administration feared that the closure of the tuberculosis service would have a negative effect on infection control. It is indeed likely that until then, the staff of this service may have overseen infection control activities. It is also revealing that the activities of the committee intensified after the closure of the Edmonton Isolation Hospital in 1963. In fact, the minutes of the medical staff meeting of December 1965 clearly indicated that the closure of this hospital had pushed the committee to establish isolation directives to be used by the entire medical and nursing personnel of the hospital. Significantly, the necessity of involving more departments in infection control planning was recognized in 1966 when representatives of the laboratory, dietary and housekeeping services were added to the committee.[940] Although it is accurate to state that isolation hospitals became obsolete because the development and usage of numerous vaccines had decreased the intensity of epidemics and the effect of common childhood contagious diseases, it may be suggested that the disappearance of these institutions was in itself beneficial in that it fostered the spread of infection control procedures and knowledge to the general hospital.

---

[935] Ibid., 1930 to 1954.

[936] "Universal precautions" is the term used to describe the current infection control system.

[937] The Keith Sanatorium was located near Calgary and served the southern portion of the province. Infection control measures used there in 1935 included: frequent hand washing, the wearing of isolation gowns and special disposal of food trays. Gibbon and Mathewson, ***Three centuries of Canadian nursing***, 438.

[938] Canadian Nurses Association, ***A proposed curriculum***, 130; See Chapter 13 for more details about the CNA statement.

[939] ASGME, EGH, MMSM, December 1952. It appears that the first policy written by this committee concerned regulations to be observed on pediatric units.

The development of specialized services

To date, the majority of authors who have studied the evolution of the hospital have focused on the significant transformations which occurred between 1890 and 1920. During this period of time the hospital gained many of the characteristics it demonstrates today. However, it is the contention of this writer that the post-WWII era, roughly delineated as the period from 1948 to 1965, was probably as significant as the aforementioned period. The importance of this period of time is obvious when considering that it was during those years that increasing specialization led to the establishment of special care units, that out-patient services became increasingly important, and that significant numbers of schools of nursing and of allied disciplines moved to the general education system. The latter movement meant that service and education became separate entities, and that nursing students and nursing faculty members became "guests in the house."[941] In Canada, the period also brought a number of changes linked to the establishment of a national hospital insurance policy and almost simultaneously the departure of many religious orders from the hospital field or as was the case at the EGH the delegation of much of the sisters' responsibilities and power to lay individuals. Some of these changes undoubtedly made the hospital an increasingly open-system. Signs of the transformation can be seen in the establishment of new services and the growing recognition that patients were consumers who could evaluate some of the services rendered by the hospital.

---

[940] ASGME, EGH, MMSM, 26 February 1966.

[941] This expression was used by Helen Glass who studied the teaching behavior of university nursing instructors in the clinical setting. In particular, she examined the diplomatic skills that had to be developed by virtue of being guests of the hospital. Helen Preston Glass, "Teaching behavior in the nursing laboratory in selected baccalaureate nursing programs in Canada," (Ed.D. diss., Teachers College, Columbia University, 1971), 129.

The new departments and programs

The emergency department

The first emergency department of the EGH opened its doors in February 1949. The chronicles revealed that two rooms were set aside and equipped to care for emergency patients.[942] It appears that the population immediately began to use the service. In May 1949, 409 patients were seen in the department. Eighteen persons were treated for fractures, 38 for minor injuries and 29 dressings, 38 minor surgical interventions, 149 treatments and 151 physical examinations were done.[943] It may be suggested that during the 1950's, the emergency department became an essential service of the EGH and of most Canadian hospitals. However, within a few years it also became apparent that emergency departments were used for other purposes than responding to emergency situations. In 1953, the minutes of the medical executive committee stated:

> Sister Superior made note of the fact that there is an increasing tendency to utilize the Emergency Room for office hours of practice. She hoped that this practice would be discouraged as it often worked a hardship on the houseman on call.[944]

This practice obviously continued since in 1957, the emergency department committee stated that there was a need to remember that the emergency room should be used for emergency care and not for routine care or treatments that could be carried out in a physician's office.[945] In 1959, Dr. Warshawski conducted a review of the department utilization which revealed that in the month selected, only 388 of the 672 patients who had been seen were "proper" emergency cases.[946] In 1961, a similar study indicated that over the previous eleven months, one third of the patients who had received services in the department could have been treated in physicians' offices. The emergency committee stated:

---

[942] ASGME, EGH, Chroniques, 4 February 1949.

[943] Ibid., 31 May 1949.

[944] ASGME, EGH, MMEM, 6 October 1953.

> Undoubtedly, these case are of real value for interns' training, but these do greatly congest the facility for the small emergency room. Cooperation from physicians is urgently needed.[947]

This statement suggests that some of the physicians who were using the department as a general practice facility probably argued that by doing so they were providing educational opportunities to medical students, and therefore that their use of the service should not be condemned. Six years later the practice of using the department for non-emergency situations had not been curtailed and the emergency committee designed regulations forbidding it.[948] Following the adoption of these regulations, it seems that some physicians blamed the nursing service for having proposed the new measures, since in it's annual report, the emergency committee stated: "These rules were recommended by the emergency committee and adopted by the medical executive, and are not a 'brain child' of nursing service."[949] In fact, it is possible that the head nurse of the department may have suggested changes considering that the condemned practice likely drained nursing resources and created additional costs which had to be absorbed in the budget of each unit. Since medical practice was being overseen by the medical department, nursing could not have unilaterally established new rules regulating physicians' work.

---

[945] Ibid., Report of the emergency department committee, 17 April 1957.

[946] ASGME, EGH, MMSM, 18 November 1959.

[947] Ibid., 20 December 1961.

[948] Ibid., December 1967.

[949] Ibid.

In summary, it is evident that one of the problems persisting in the 1990's was identified at the EGH soon after the establishment of this department. Today, patients are often considered the cause of the problem. It is argued that many elect to go to emergency departments for minor ailments instead of using community clinics or physicians' offices. That some patients use emergency departments in this fashion cannot be negated. However, it is known that these patients constitute a very small proportion of the population. Based on the EGH data of the 1950's and 1960's, it may be suggested that the problem experienced was created by some medical practitioners who consciously or not contributed to the development of the tendency to use the emergency department as a general clinic. It must be noted that the EGH data never included statements suggesting that the patients were to be blamed for the situation. It is thus clear that the idea of making the patient the scapegoat developed in later years. However, it is just as clear that today's rhetoric does not recognize the historical root of the problem which from experience in the health care system one would conclude has not disappeared entirely. It is clear that some physicians still say to their patients: "If you have any concerns come and see me in the emergency department."

Premature babies unit

A unit for premature infants was established in 1954.[950] The chronicles indicated that planning began in 1953 and that the ladies aid society held a fundraising luncheon where $2,000.00 were contributed towards the purchase of incubators.[951] The opening of the service was timely since Edmonton was in the midst of the baby boom. Mortality statistics for 1962 suggest that the unit offered quality services to premature infants. That year, only 28 infants did not survive out of the 296 who were admitted.[952] Even if the gestational age of these premature infants could not be determined, the survival rate was remarkable considering that neonatology was in its infancy. Evidence suggests that physicians and nurses who worked on the unit formed a cohesive and efficient team. In his report Dr. Beauchamp stated: "The large part of the credit goes to the very excellent and dedicated nursing staff that we have in this department."[953]

---

[950] ASGME, EGH, Chroniques, 6 February 1954.

[951] Ibid., 13 May 1953.

[952] ASGME, MMSM, Annual report of the department of pediatrics, by Dr. Beauchamp, December 1962.

Surgical recovery room

In 1954, the sisters took the initiative to establish a recovery room adjacent to the operating rooms.[954] It is very likely that the creation of this unit was a nursing initiative since postoperative stabilization was primarily a nursing responsibility. This would seem to be a reasonable conclusion since the first recovery rooms in other locations were developed by nurses,[955] and since the minutes of the medical staff meetings did not contain any information about establishment of the unit. The value of such unit to patient care cannot be underestimated since patients received close supervision and nurses working in the area had special expertise in the area of early postoperative care. Significantly recovery room units are also better equipped to deal with emergency situations than regular ward rooms.

Evidence suggests that the Grey Nuns showed particular concern for surgical patients. In her reminiscence about her nursing education at the EGH in the early

---

[953] Ibid.

[954] ASGME, EGH, Chroniques, 30 June 1954.

[955] The movement towards the creation of recovery units arose from nursing's realization that patients could not be left unsupervised after surgical procedures. John E.M. Camporesi, W.J. Greeley, P.D. Lumb and W.D. Watkins, "Anesthesia," in ***Textbook of surgery, the biological basis of modern surgical practice***, 13th ed., ed. David C. Sabiston, (Toronto: W.B. Saunders Company, 1986), 168.; Nurses have been the prime movers in establishing this critical area, and some even attribute the original idea to Florence Nightingale, who apparently suggested the creation of such units in 1863. It appears that recovery rooms began to exist in the early 1900's. For example, such room was established at the Johns Hopkins Hospital in 1923. However, it is important to note that recovery rooms became common only after WWII. Elizabeth A. M. Frost, "Introduction," in ***Post Anesthesia Care Unit, current practices***, 2d ed., ed. Elizabeth A.M. Frost (Toronto: The C.V. Mosby Company, 1990), xix-xxi.

1930's, Gahagan wrote that the sisters asked her to accompany a little girl to the operating room because she was fearful and anxious about the imminent surgery.[956] Such an approach to care was certainly not the norm at the time. In 1956, the minutes of the Medical Executive Committee presented concerns about late surgical bookings because the practice was a source of problem for the hospital anesthetists. The Superior of the EGH corroborated this view but added that last minute changes were troublesome for patients and that their needs had to be the priority.[957] It seems that the issue was resolved. However, evidence suggests that at times physicians had to be reminded that respecting schedules was an important efficiency factor in running an operating room. In 1959, Dr. J.P. Moreau, the chairman of the surgical committee reminded surgeons, in a very colourful manner, of the importance of punctuality:

> Surgeons, as all humans are status seekers. Forty or fifty years ago a surgeon's status was determined in a community by the number of horses he had in his stable, or by the quality of his wife's clothes. With the advent of the automobile, a better surgeon prided himself in the size and speed of the car he drove. More recently, a successful surgeon could be recognized by the roominess of his house, and the length of his basement bar. A more reliable guide today, gentlemen, to a surgeon's status, is the interval between the slated time of his surgery and his appearance in the operating room. Thus will you recognize the masters.[958]

The care of diabetic patients: a model of out-patient services

In 1960, Dr. G. Brown, a champion of the diabetic patient care in Edmonton, expressed the view that since the hospital usually admitted 30 diabetic patients every month it would be appropriate to hire a nursing instructor whose role would be to provide specialized instruction. He stated: This census indicates the desirability of a full time nurse for lecturing to student nurses and also for the teaching of diabetic patients which is an essential part of treatment.[959]

---

[956] Gahagan, ***Yes Father***, 68.

[957] ASGME, EGH, MMSM, 20 November 1956.

[958] ASGME, EGH, MMSM, Annual report of the surgical committee, by Dr. J. P, Moreau, December 1959.

Two years and a half later, his suggestions having not been acted upon, Dr. Brown wrote the following to the president of the medical staff:

> Several years ago discussion were held by the executive concerning the appointment of a full time Diabetic Teaching Nurse. At the time, Sister Superior stated that further investigation would be carried out but to date no appointment has been made. At present time, there are from 30 to 50 diabetic patients in the hospital at all times. Many of these patients are serious nursing problems related to their lack of knowledge in the care of their diabetes. The Clinical Instructors [of the school of nursing] on each ward are making a good attempt to aid the doctors in the education of their diabetic patients but too often duties intervene with insufficient instruction for good success at home.
>
> It is again sincerely requested that the administration consider the appointment of a Senior Graduate Nurse, preferably with her B.Sc. to assume overall direction of Diabetic Teaching at the EGH.[960]

Significantly, he also mentioned at the end of his letter that the UAH, RAH, and Misericordia Hospital had recently created such positions. Awakening the competitive spirit was probably a good strategy, since the EGH appointed a nurse and started a diabetic teaching program.[961] In the first years of operation the program was offered only for patients who were admitted at the EGH, and teaching activities were done at the bedside. In 1968, the hospital opened the Diabetic Instruction Centre (part of the nursing division of the hospital) which purpose was included the teaching of in-patient as well as the teaching of out-patients. The centre had three objectives:

1. Assist diabetic patients in understanding and living with their condition, thereby reducing the number of readmissions to the hospital.

---

[959] ASGME, MMSM, 5 October 1960.

[960] ASGME, MMSM, Letter of Dr. G. Brown to Dr. J.R. Leeder, President of medical staff. Carbon copy to the EGH Superior, 5 March 1963.

[961] The exact date could not be determined.

2. Provide a therapeutic milieu for patients without having to admit them.
3. Provide learning experiences for student nurses, student dieticians, interns and residents.[962]

The scope of these objectives reflected some of the changes which were occurring in the hospital world at the time. The first objective corresponded to the increasing recognition that patients needed to be informed and that active participation in their own care could improve their wellbeing and reduce the risk of potential complications. The second objective indicated the view that patient admission was not a necessary condition for the provision of hospital services. Finally, the third objective confirmed that it was part of the mission of the hospital to educate health care professionals.[963] Significantly, the centre was staffed by a nurse, a dietician, and a physician who collaborated in the provision of patient teaching. The first Annual Report of the centre revealed that between July and December 1968, 173 patients attended classes. Of these, 121 were out-patients, including 65 newly diagnosed diabetics.[964]

To date, diabetic teaching centres have remained models in terms of patient teaching and collaborative practice in which the skills of all health care professionals are acknowledged and used to benefit the patient population. It may be suggested that endocrinologists have been at the forefront of the patient teaching movement within the field of medicine. Many of their patients were diabetics and the nature of the disease was probably an important factor which made them recognize earlier than in other areas of medicine the importance of patient teaching. In terms of the EGH, it is clear that Dr. Brown provided the leadership which led to the establishment of a diabetic teaching centre. It is somewhat surprising that the Superior did not immediately responded to the first request of this physician, since patient teaching was part of the nursing curriculum at the time and that it had long been a nursing value to provide information. Financial considerations might have played a role, since hiring an additional nursing instructor was relatively costly. It may also have been that initially the sisters did not recognize the need to have a nursing instructor whose role would be limited to diabetic teaching. The sisters may have felt simply believed that the staff of the School of Nursing could meet the needs of students and patients alike.

---

[962] ASGME, EGH, MMSM, 15 June 1968.

[963] Ibid.

[964] Ibid., Annual report of the Diabetic Instruction Centre, December 1968.

Civil defense and casualty alert plan

Although the development of a civil defence movement did not necessitate the creation of a new department, the topic is relevant to the post-WWII era and to the establishment of programs designed to mobilize personnel in times of crisis. The first mention of civil defence activities was made in the chronicles of February 1952 when it was stated that all nursing students and registered nurses had taken a two-hour course on civil defence and nuclear warfare.[965] For the remaining years of the decade and for much of the 1960's the provision of civil defence courses was mentioned on a regular basis and three sisters were even sent to Ottawa for a special one week session.[966] Of interest, between 1945 and 1965, *The Canadian Nurse* published twenty-five articles and five editorials ranging from how to deal with victims of nuclear attacks to the construction of nuclear shelters.[967]

It has been established that the civil defence movement arose in response to the Cold War and the associated fear of Soviet nuclear aggressions against Canada and the United States.[968] Because of this fear, the Departments of National Defence and of Health and Welfare began to sponsor courses designed to prepare health care professionals to respond to nuclear attacks. It was also considered urgent to develop emergency plans at the local level, and consequently, hospitals were asked to prepare emergency situation plans. On October 19, 1960, the EGH conducted its first disaster exercise during which 50 nursing students and 50 soldiers of the Princess Patricia Regiment served as casualties.[969] Apparently, the exercise was a success and the administration decided that the department of nursing would ensure that the plan was always kept current and that exercises were conducted on a regular basis.[970]

---

[965] ASGME, EGH, Chroniques, 27 February 1952.

[966] Ibid., 1952 to 1967.

[967] ***The Canadian Nurse***, 1945 to 1965.

[968] The Royal United Services Institute for Defense Studies, ***Nuclear attack and civil defence; aspects of civil defence in the nuclear age***, (Toronto: Bronsey's Publishers Limited, 1982), 210.

Looking back on the 1960's it seems that everyone involved was rather naive about what could be the results of a nuclear attack. Clearly the disaster plans would have been of limited use if the atomic bomb had been dropped over Canada. However, the beginning of planning for potential disaster was a positive development considering that this could be useful in emergency situations of all types. The value of casualty alert plans was certainly confirmed when on July 31, 1987, the worst tornado in canadian history ripped through the Edmonton area. Undoubtedly, the response of the UAH and the RAH which received most of the casualties would not have been nearly as efficient if such plans had not been in place. Considered from that point of view, the conclusion may be drawn that disaster planning was a positive outcome of the Cold War era.

The first intensive care unit

Planning for the establishment of the first intensive care unit (ICU) began in November 1966 and by January 1967, a proposal of unit policies had been developed by three physicians and three nurses.[971] As stated earlier the preparation of nurses who worked in the ICU was one of the first issues of concern.[972] In 1969, it was decided to solve the problem by developing a special orientation programme for the ICU nurses, since the province did not offer any post-diploma ICU courses.[973] It thus seems that by 1969, it was beginning to be recognized that diploma preparation was insufficient and that nurses needed further education to work in the field. It is possible that the refusal of the school to send students to the unit pushed the hospital to take the initiative of instituting a special program to prepare nurses for ICU nursing. Although such a programme was not ideal, it certainly was a step in the right direction and was educationally more sound than attempting to teach a specialty to beginning diploma nursing students via an apprenticeship in the area.

---

[969] The EGH exercise was the first being conducted in Alberta. ASGME, EGH, MMSM, 20 October 1960.

[970] Ibid., 20 December 1961.

[971] Noteworthy, two of the nurses were lay individuals. ASGME, EGH, MMSM, 1 November 1966 and 5 January 1967.

[972] See the chapter on the school of nursing for further details.

In general, the opening of an ICU was in important step reflecting the changes taking place in the health care arena. The hospital was increasingly becoming a technological world and new monitoring and life saving devices allowed for saving the lives of patients who would have been lost a few years earlier.

The department of nursing

Although not a new service in the same sense as the above patient care units, it may be suggested that the separation of the School of Nursing from nursing service which occurred in 1955 transformed the nursing service department into a separate and unique entity. In particular, the creation of the position of Director of Nursing Services gave a new voice to nursing within the hospital structure. Importantly, it contributed to clarifying the roles and functions assumed by professional nursing in the hospital. It is significant that in the months following the establishment of the new nursing structure, head nurses began to meet on a regular basis and to report formally on the nursing care being carried on at the unit level.[974] It also appears that during the 1950s continuing nursing education became more structured[975] and guests speakers started to be invited on a regular basis.[976] In 1970 the department of nursing was remodeled and continuing nursing education became the responsibility of an assistant director of nursing.[977] These changes suggest that accountability was becoming an increasingly important variable. In fact, it was stated in the hospital accreditation report of 1970 that the EGH provided excellent nursing care but that a nursing audit system should be implemented as soon as possible.[978] These comments of the accreditation team lend support to the belief that the concept of quality nursing was undergoing change in Canadian hospitals. It is important to note that although an official nursing audit did not exist, from 1953 on the hospital provided patients with an evaluation form which included nine questions about aspects of the care received at the EGH.[979] The introduction of this tool and the national movement towards audit systems clearly indicate that attitudes were changing and that patients were starting to be seen as consumers of health care services. It is believed that the introduction of a radio service in 1954 and a patient library service in 1967 was related to the emergence of this new trend.[980]

---

[973] Ibid., 13 March 1969.

[974] ASGME, EGH, Chroniques, 2 June 1955.

[975] In 1952, the hospital hired a nurse whose role was to provide inservice education to the nursing staff. ASGME, EGHS, 1952.

---

[976] ASGME, EGH, Graduées en service - Infirmières Edmonton, Statuts, 1956.

[977] The new structure included, an Assistant Director of Nursing Service, an Assistant Director of Nursing Inservice Education, an Assistant Director of Nursing for evenings and one for nights. ASGME, EGH, Board of Management papers, Nursing care organization, 1970.

[978] ASGME, EGH, MMSM, Extracts of Accreditation Report of August 1970.

[979] These questions were: "-1- Was your reception at the hospital cordial? Sympathetic? -2- Were your nurses competent? Attentive? -3- Were you satisfied with the cleanliness? with the quietness? -4- Were your meals well prepared? Sufficient? Served hot? -5- Considering your physical condition do you think you had too many visitors? Too few? -6- Was the service of interns satisfactory? Agreeable? -7- Was the personnel of the different offices polite? Obliging? Kindly? -8- Was the service of the telephone operator prompt? Courteous? -9- Were you satisfied with the service of the librarian?" ASGME, EHH, Doc. 256, Evaluation questionnaire, August 1953.

[980] The radio rental service consisted of radios that were coin operated. For ten cents a patient could have one hour of listening. ASGME, EGH, Chroniques, 31 March 1954; Volunteers circulated with carts from which patients could borrow reading material. ASGME, EGH, Chroniques, 24 May 1967.

The relationship between medicine and nursing

The delegation of medical acts

Prior to 1943, data pertaining to the relationship between medicine and nursing primarily concerned the school of nursing, and nursing students. After that year, information pertaining to the responsibilities of graduate nurses began to be found on a regular basis in the minutes of the medical staff meetings. In fact, these minutes constituted the only source of information illustrating the relationship between registered nurses and physicians. Not surprisingly, the data found in these minutes primarily concerned the delegation of medical acts to the nursing staff of the EGH. It may be suggested that if a nursing source of information had been available that other aspects of the complex relationship between the two professions might have been described. Nonetheless, much of the relationship between nursing and medicine is shaped by the fact that nurses perform a number of functions which are within the realm of medicine while the reverse does not often occur. It may be suggested that this aspect of the medicine/nursing relationship explains in large part why the general public tends to believe that decision making is an attribute of medicine only. What is often not understood is that, in many cases, a nursing decision precedes the medical decision. Thus, based on her observations, a nurse will decide that medical input is required. In many circumstances, physicians rely largely upon this nursing input to make their own decisions. The delegation of medical acts is in fact more than simple task delegation, and implies that assessment becomes a shared responsibility and consequently that collaboration is a necessary condition to quality patient care.

It is usually agreed that the delegation of medical acts to the nursing profession accelerated after WWII. Results presented in this section confirm this view and suggest that delegation was a matter of convenience and/or necessity. In general, it may also be suggested that the rapid development of new technological tools and therapeutic modalities contributed to further delegation, and that the decision to delegate usually occurred once a number of conditions had been met. Finally, the separation of the school of nursing from the nursing service and the increased presence of graduate nurses contributed to a broadening of the nursing role.

In December 1944, the EGH physicians adopted the motion that "... during the next year, due to the shortage of interns, the nurse in charge may phone the doctor about the patient's arrival or change in condition."[981] Similarly, at some point during the war, nurses were delegated responsibilities in the practice of intravenous fluids administration. However, soon after WWII the physicians "... adopted that hereafter, interns be required to do all the intravenous work, which the nurses have been doing during the war rush."[982] Interns were also given back the responsibility of phoning physicians about variations in patients' condition. Within seven years both responsibilities were returned to nursing and nurses were also asked to administer intravenous antibiotics and monitor blood transfusions.[983] The events which led to the permanent delegation of the administration of intravenous fluids illustrate very well the manner in which delegated acts were added to the list of nursing responsibilities. The data indicates that during WWII a shortage of interns led to the delegation of this medical act. It may be suggested that the transfer of this responsibility was seen as a matter of necessity. Someone had to do this work which was part of what interns usually did. When the war ended and interns were once again available, their old responsibilities were returned to them. However, during the war, intravenous therapy and blood transfusion procedures had been refined and their use thus became increasingly common on patient care units. Even if interns were no longer a rare commodity, the number of patients receiving intravenous fluids increased so much that they could not meet the demand. Consequently, it was necessary to find an alternative and since nurses constituted a large workforce and their ability to perform this procedure had been demonstrated during the war years, it became convenient if not necessary to let them perform this medical act.[984]

---

[981] ASGME, EGH, MMSM, 20 December 1944.

[982] Ibid, 7 March 1946.

[983] ASGME, EGH, MMEM, December 1951; MMSM, 27 October 1953.

[984] In respect of blood transfusion, the EGH nurses of the 1950's were only responsible for monitoring. It was only in 1963 that nurses were allowed to initiate blood transfusions ordered by physicians. ASGME, EGH, MMSM, 13 September 1963.

By the mid-1950's the door to delegation had been wide open and a number of procedures which had been done only by physicians or interns began to be performed by nurses. Consequently, tasks such as suture removal, insertion of naso-gastric tubes, skin traction, tracheotomy care, and more complex dressing changes became part of the nursing routine.[985]

Standing orders

In 1949, the physicians wrote the first list of standing orders.[986] In the following years, nurses began making suggestions to modify the content of the list. For example, in 1954, Miss V. Protti, one of the nursing instructors, proposed that the vital signs of long term patients be taken only twice daily as opposed to four times a day. A group of staff nurses also proposed that the routine insertion of naso-gastric tubes prior to surgery no longer be done as a routine procedure but only when explicitly specified by the surgeon.[987] In 1961, the Superior of the EGH asked that standing orders be reviewed by a medical/nursing committee.[988] Two years later, a special meeting was organized to review the policies of all medical procedures performed by nurses.[989] Significantly, in 1963, the administration decided to establish a permanent nursing/medical committee whose responsibility would be to address issues of concerns of both professions. It appears that the establishment of the committee was well received. In particular, Dr. Allard, commented that such committee was of "considerable importance" since it would provide a formal channel of communication between nurses and physicians.[990] Importantly, in 1967, the committee stated:

---

[985] In 1968, the Council of the College of Physicians and Surgeons, the Executive of the Alberta Medical Association, the Alberta Association of Registered Nurses and representatives of the Alberta Hospital Association agreed and confirmed that these procedures could be done by nurses. ASGME, EGH, MMSM, Letter of R.F. Clark, Executive Secretary of the Alberta Medical Association to administrations, chiefs-of medical-staffs, directors of nursing and Alberta hospitals, 26 February 1968.

[986] ASGME, EGH, MMSM, October 1949. Standing orders consist of procedures, tests, ect... which are uniformly done for a physician's patients and which can be executed prior to the writing of the actual order in the patient's record.

[987] ASGME, EGH, MMEM, 5 October 1954 and 7 December 1954.

[988] Ibid., 8 November 1961.

[989] Four physicians and three nurses participated in this review. ASGME, EGH, MMSM, 13 September 1963.

> The nursing service will draw up a list of routine orders and then draw them to the attention of the medical personnel concerned, and ask for approval. It is felt that head nurses should be trusted to have some judgment in the care of patients and could give certain treatments without first having it written down.[991]

This chronological overview indicates that the relationship between nursing and medicine significantly changed between 1947 and 1967. Because physicians increasingly relied upon nurses for the implementation of their therapeutic regimen, they had to increasingly share their decision making power. It may be suggested that this sharing was made necessary because the delegation of medical acts could not be done without the delegation of responsibility. In many cases, the performance of these acts necessitated judgment calls and the gathering of essential information used by the physicians to guide their decision making. Conversely, as nurses realized the importance of their new roles they also claimed more decision making power. The passage from a nursing student workforce to a professional workforce certainly contributed to the emergence of the new medical/nursing relationship. As professionals, registered nurses could ask to be treated as peers, which could not have been requested by nursing students. Significantly, most of the changes which occurred at the EGH in respect of standing orders and delegated acts took place after the separation of the school of nursing from nursing service which indicates further that the establishment of a "proper" nursing department altered the relationships between nursing and medicine.

It is useful to provide a concrete example about the phenomenon of the delegation of medical acts. The task of changing a postoperative dressing can serve as an example of what is implied in the daily routine of a staff nurse. When a nurse changes a patient's dressing, she simultaneously collects important information about wound healing. While performing this task, the nurse is also usually the first to observe anomalies. For example, if a nurse noticed a purulent discharge, she would decide that a wound swab must be collected and sent to the laboratory in order to determine the causal agent of the apparent infection. She would also decide to inform the physician of the patient's wound status. In this case the nurse's clinical observations are necessary for medical practice and, once conveyed to the physician, would be used to determine the changes which need to be made in the patient's medical regimen since the surgical wound was not healing well. Strictly speaking, when the nurse decided to take a swab she was making a medical decision, since prescribing laboratory procedures is a medical prerogative. However, in doing so she performs what has become expected in such a situation since the test is necessary to establish a medical diagnosis and since by deciding to act immediately she ensures that the causal agent is discovered more rapidly. It is unlikely that a nurse of 1949 would have reacted in the same manner. She probably would have had to wait for a physician's order prior to collecting the specimen. However, as time passed the realization that allowing nurses to make such decisions could be valuable for patient care undoubtedly made physicians recognized that the sharing of responsibility for care could be an asset in their work. In general, it can be stated that a number of practices that were originally medical functions have become integral components of nursing, and that medicine also considers them to be more nursing functions than medical functions.

---

[990] ASGME, EGH, MMEM, 1 April 1964.

[991] Ibid., Report of joint nursing/medical committee, 4 October 1967.

The medicine/nursing relationship is characterized by the complexity of its nature. In particular, resistance to change has always existed and some physicians see nursing as a threat every time more responsibilities are transferred. It must be noted that the transfer of functions is not unique to medicine, but rather that nursing also transfers and delegates functions to registered nursing assistants and others. It is also evident that many tools that were once used only by professionals are now in the public domain. In general, this type of transfer occurs once technologies have been demystified and have become "user friendly". For example, the taking of a temperature was originally performed only by physicians. Later on this function was shared with nursing, while now lay individuals commonly use the thermometer. Significantly, lay people are usually able to determine if the recorded temperature indicates the need to consult a health care professional. This example shows that the transfer of functions does not remove the reliance on experts when necessary, but rather, that empowering people and sharing knowledge is in fact beneficial since abnormal conditions are reported more rapidly and lay people can assume responsibility for their own health.

In the last two decades the evolution of the delegation of medical acts to the nursing profession has also been examined from new vantage points. It is believed that the significant growth in nursing knowledge that has occurred since the 1970's is modifying the relationship between the two professions. Nursing increasingly considers that its role is complementary to that of medicine. Consequently, the unquestioned transfer of medical functions is seen as detrimental since the more a nurse has to perform delegated medical acts the less time she has to fulfil nursing functions. In Canada, the work of Allen has been instrumental in the development of this school of thought: the role of nurses is to provide nursing care rather than replacing physicians in functions that are primarily of a medical nature.[992] In general, it is increasingly acknowledged that nursing has a unique role to play in the delivery of health care services and that a better utilization of the nursing workforce would have a tremendous impact on the health of Canadians.

In conclusion, the data presented in this chapter indicates that the EGH attempted to respond to the health care needs of the population and that administrative choices reflected public health concerns and political contingencies. The available data also reflected the fact that the needs of the population changed during the 76 years under study, and that as an institution the hospital had to adapt to changing demands. The period of time from 1950 to 1970 was also marked by the development of specialized areas of practice, and by the fact that medical responsibilities were increasingly delegated to nurses. In addition, the establishment of a new nursing administrative structure in 1955 reflected the rising professionalization of nursing. Finally, it may be suggested that the emergence of out-patient services, including the establishment of a diabetic teaching centre, the introduction of a tool by which patients could evaluate hospital services including nursing care, and the availability of new recreational items such as radios and books indicate a modification of the concept of the role of the consumer of health services in which patients were seen.

---

[992] See Moyra Allen, "Primary health care: research in action," in ***Recent advances in nursing, Primary care nursing***, ed. Lizbeth Hockey, (Edinburgh: Churchill Livingstone, 1983), 32-77; Mona Kravitz and Maureen A. Frey, "The Allen nursing model," in ***Conceptual models of nursing: analysis and application***, 2d ed., ed. Joyce Fitzpatrick and Ann Whall, (Norwalk, Connecticut: Appleton and Lange, 1989), 313-329; Laurie Gottlieb and Kathleen Rowat, "The McGill model of nursing: A practice derived model," ***Advances in Nursing Science***, 9, (July, 1987): 51-61.

CHAPTER 15

THE EGH AS A CATHOLIC INSTITUTION

This chapter concerns the beliefs and religious tradition which shaped the Roman Catholic nature of the EGH.[993] It is evident that the sisters by virtue of belonging to a religious order were involved in religious activities and that they paid great attention to the spiritual needs of the patients and staff of the EGH. Although it is beyond the scope of this project to study the spirituality of the Grey Nuns, it is nonetheless necessary to present an overview of some of the values of the order, of the days and months of the year which were of major importance in their religious lives, and of how their religion contributed to their philosophy and was part of their nursing care. It is also relevant to examine how Catholic morals played a role in patient care delivery and in particular how it prohibited the practice of a number of medical acts which were considered transgressions of these morals. Finally, it is of interest to present evidence of the religious commitment displayed by some of the EGH physicians.

The Grey Nuns

The legacy of Marguerite d'Youville

In Catholic orders the founder is seen as a central figure who serves as a model for the future generations of the particular religious family. Thus, a religious order must be seen as a whole and in relation to the founder with whom the followers are closely linked.[994] Marguerite d'Youville, founder of the Grey Nuns, was born at Varenne, Quebec, in 1701 and like a number of leaders who founded religious orders, she chose religious life after the death of her husband. In 1737, Madame d'Youville and her friend Marie-Louise Thaumur began to take care of poor and sick people in Montreal. Ten years later, other women had joined them and the fledging order was given charge of the *Hôpital Général de Montréal* which until then had been operated by the Charon Brothers, whose leader, Brother Charon, had founded the institution. By the time of her death in 1771, the order was well established even if a number of difficulties had characterized the beginning of the enterprise.[995] The purpose here is not to present a biography of Marguerite d'Youville but rather to examine her religious beliefs and the particular devotions she transmitted to her followers. These are relevant since they were reflected in the religious life of the sisters of the EGH.

---

[993] The involvement of the Grey Nuns in the Catholic Hospital Association and the transmission of Catholic values to nursing students have been addressed in previous chapters. Therefore, even if these topics are related to the Catholic nature of the EGH they are not specifically examined in this chapter.

[994] Micheline D'Allaire, ***Vingt ans de crise chez les religieuses au Québec 1960-1980***, (Quebec: Editions Bergeron, 1983), 39.

All members of Catholic religious orders make the vows of poverty, chastity and obedience. In taking these vows, the sisters give their lives to God and choose to live according to the Gospel. The vow of poverty is closely linked to charity since it implies the sharing of material goods to the benefit of the poor.[996] It can be suggested that this vow was of primary importance to Mother d'Youville. It has also been stated that "It was in this evangelical poverty that the foundress [and the first sisters] set the basis for the institute."[997] The fact that d'Youville devoted her life and the lives of those in her order to the service of the poor also highlight the importance placed on charity. The Catholic Church officially recognizes that charity was central to Mother d'Youville's conception of religious life. In 1959, when she was beatified by Pope John XXIII, he proclaimed her "Mother of Universal Charity", and this title was directly conferred at her canonization in December 1990.[998]

---

[995] Details about the life of Marguerite d'Youville and the beginning of the Grey Nuns may be found in a number of biographies, among them the following are most often cited: Charles Dufrost, *Mémoire pour servir la vie de Madame d'Youville*, (No date, no edition, was certified as authentic by the Grey Nuns Order and printed in 1925 in the Rapport de l'archiviste de la province de Québec [Quebec, Queen's printer, 1925]). Dufrost was one of the sons of d'Youville and probably wrote this biography soon after her death; Antoine Sattin, *Vie de Madame d'Youville*, (Quebec: no edition, 1829); (E.M. Faillon, *Vie de Madame d'Youville - Fondation des Soeurs de la Charité de Ville-Marie en Canada*, (Paris: Périsse Frères, 1852); A. Ferland Anger, *Mère d'Youville première fondatrice canadienne*, (Montreal: Librairie Beauchemin, 1945); Albina Fauteux, *Love spans the centuries*, translated by Antoinette Bézaire from the original French edition of 1915: "L'Hôpital Général des Soeurs de la Charité" (Montreal: Meridian Press, 1987). Although this book is not specifically a biography of d'Youville it includes important biographical information about the spirituality of the foundress and was the first written by a Grey Nun.

[996] D'Allaire, *Vingt ans*, 131.

[997] Fauteux, *Love spans*, 81.

The vow of chastity is difficult for contemporary lay people to understand. It can be said that in choosing a celibate life sisters and brothers live another form of poverty. By selecting not to have "erotic love" their love is transformed into "charitable love".[999] Another way to understand chastity is considering that by remaining pure the sisters could be more receptive to God's will. This last explanation was likely the one subscribed to by Mother d'Youville and other Catholics of the 18th century. Unfortunately, her biographers did not include evidence about her views concerning the concept of chastity.

Simply defined, obedience has usually meant to follow the orders of the religious superior. Of interest, after Vatican II, Rome asked for responsible obedience, a type of obedience bound in maturity and in the respect of individual personalities.[1000] It may be suggested that Mother d'Youville's views on obedience were close to the spirit of Vatican II, since it is believed that she said: "Walk always in the path of regularity, obedience and mortification; but above all, let the most perfect union reign among you."[1001] Hence if union and harmony were essential to the communal life there had to be a minimal respect of personalities in order to reach this goal.

The three members of the Holy Family were central to d'Youville's spirituality. Devotion to Jesus took a number of forms. In particular, the worship of the Sacred Heart was primordial to her religious life as was the devotion to the Holy Cross.[1002]

---

[998] Vaticana, ***Canonizzazione della beata Marie Marguerite d'Youville***, (Roma: Tipographia Poliglotta Vaticana, 1990), 7.

[999] Alfred Ducharme, sj, ***Une dynamique communautaire de la foi - la communauté religieuse***, (Montreal: Editions Bellarmin, 1982), 59.

[1000] D'Allaire, ***Vingt ans***, 145.

[1001] Soeurs de la Charité de Montréal, ***Les Soeurs Grises***, (Montreal: Author, 1987), 43.

[1002] Fauteux, ***Love Span***, 104-105.

Her devotion to the Sacred Heart dated from her childhood when she belonged to the "Co-fraternity of the Heart of Jesus" at the Ursulines' Convent in Quebec City where she had been a student.[1003] The importance she gave to the feast of the Holy Cross has been attributed to the fact that it was a central devotion of the brothers who had funded the *Hôpital Général de Montréal* and that she decided to incorporate their traditions in her institute.[1004]

It has been written that from her "... devotion to the Sacred Heart flowed a tender devotion to the Immaculate Heart of Mary. [...] On awakening and throughout the day she called upon Mary. At night she dedicated to her, last homage and thoughts."[1005] Mary was a key figure for the colonists of New France. The fact that Montreal was first named *Ville-Marie* is a good indication of the place she occupied in the minds of the settlers. *Les Annales de l'Hôtel-Dieu de Québec* also reveal that the soldiers who fought William Phipps at Quebec in 1690 attributed their victory to the support of the Virgin Mary.[1006] It is thus believed that d'Youville's devotion to Mary was linked to the place given to the mother of Jesus in the colony.[1007] The Virgin Mary continued to be important to French Canadian Catholics and the custom of praying to her daily continued well into the 1960's when via the radio waves Cardinal Léger of Montreal recited the rosary and thus reached the homes of the nation. Praying to Mary for peace and war victories also continued to be common in French Canada and in the Catholic world in general. It is no coincidence that during World War II, the Pope usually requested special prayers for peace in the months of May and October which are the months devoted to Mary in the Roman Catholic calendar.[1008]

[1003] Fauteux, ***Love spans***, 105; The devotion to the Sacred Heart has always been strong among French Canadians. It was particularly intense in the 1920's. Nive Voisine, ***Histoire du catholicisme québécois***, (Montreal: Boréal Express, 1984), 352-353.

[1004] Fauteux, ***Love spans***, 104.

[1005] Ibid., 251.

[1006] Jeanne-Françoise Juchereau & Marie-Andrée Duplessis, ***Les Annales de l'Hôtel-Dieu de Québec 1636-1716***, (Québec: Hôtel-Dieu, reprint of 1984), 252-265.

[1007] Fauteux, ***Love spans***, 251.

It may be suggested that her devotion to Saint Joseph came from the customs established by the brothers of the *Hôpital Général*.[1009] Saint Joseph was honoured as the guardian of the Holy Family and in 1771, a few months before her death, d'Youville ordered a painting of the Saint because she wished to entrust her order to his care.[1010] It has already been stated that the EGH sisters relied on the assistance of Saint Joseph when financial difficulties were threatening the hospital. This practice was directly linked to the devotion to Saint Joseph:

> La dévotion à saint Joseph est solidement établie chez les Soeurs Grises. On reconnaît en lui le modèle des âmes contemplatives, vouées à l'action et l'on s'efforce d'assurer la subsistance des pauvres dans l'esprit même où, autrefois, saint Joseph a veillé sur le bien-être matériel du grand Pauvre dont il avait charge. D'où vient que les économes le prient tout particulièrement.[1011]

It also happened that the Grey Nuns implored Mary and Joseph simultaneously. For example at the EGH, on April 12, 1901, both were asked for assistance in a very formal way. That day all sisters of the EGH signed a written pledge by which they promised to pray to both saints. The pledge was as follows:

> A la fin de la consolante visite de Notre Très Honorée Mère Filiatrault Supérieure

---

[1008] In the EGH chronicles all noted papal requests for prayers during World War II occurred in May and October. ASGME, EGH, Chroniques, October 1941, May 1942, May 1944 and October 1944.

[1009] Fauteux, ***Love spans***, 106.

[1010] Ibid., 253.

[1011] Quote translation: The devotion to Saint Joseph is solidly established in the Grey Nuns Order. We recognize in him the model to be followed by contemplative souls devoted to action and we try to ensure that poor people have enough to live on in the same spirit as, a long time ago, Saint Joseph oversaw the well being of the great Poor who were under his care. This is why the *économes* (the sisters in charge of finance) pray him regularly. Estelle Mitchell, SGM, ***Mère Slocombe, neuvième supérieure générale des Soeurs Grises de Montréal***, (Montreal: Fides, 1964), 97.

> Générale, le 12 avril 1901 et sous sa pieuse inspiration, vu le manque de ressources pécunières et les embarras que suscitent les ennemis contre notre oeuvre, nous soussignées faisons la promesse ci-dessous pour un an.
>
> 1- Chaque mois, le dernier Vendredi, chaque soeur fera une petite visite devant une image de Notre Dame des 7 Douleurs et y récitera 7 Ave Maria avec les invocations qui se trouvent dans notre manuel page 415. Ce même jour, une soeur, à tour de rôle communiera aux intentions voulues.
>
> 2- En l'honneur de St-Joseph une messe sera dite le premier mercredi de chaque mois et une communion se fera tous les mercredis. Au salut du dimanche on chantera un hymne ou invocation au Puissant et Charitable Econome des communautés religieuses.[1012]

This great reliance on saints may be difficult to understand for Christians who are not Roman Catholics. Some may think that Catholics consider the saints as gods since they use prayer to request their assistance. This is not the case. In lay terms it can be stated that the saints are used as a form of lobbying. The use of such a system makes perfect sense from a psychological point of view since it is patterned on behaviours found in human families. Who has not asked the most lenient parent to convince the stricter parent that a permission or favour should be granted? Who has not asked a sibling to convince a parent that they should consider a request? The same system was and is used by Catholics to bring messages to God. In addition, if one considers the traditional French Canadian society, to a large extent matriarchal, it is not surprising that Mary occupied a central role in the Roman Catholic culture of that group. Family having always been of primary importance for French Canadians, it is not surprising that Mother d'Youville and the Grey Nuns, the majority of whom were French Canadians, would have been predominantly devoted to the Holy Family. It is thus not strange either that in the Grey Nuns Order, and specifically at the EGH that aside from Christmas and Easter; the Feast of *Corpus Christi*, the Holy Cross Day, the Assumption, the Annunciation, and the months of Mary (May), of the rosary (October), and of Saint Joseph (March) were greatly celebrated.[1013]

[1012] Quote translation: At the very consoling visit of our Very Honourable Mother Filiatrault Superior General, on April 12 1901, and under her pious suggestion, because of our financial difficulties and because of the problems created by the enemies of our mission, we the undersigned, make the promise to do the following for one year: 1- Every month, the last Friday, each sister will pay a visit to a picture of Our Lady of Seven Sorrows, will recite 7 Ave Marias, and read the invocations on page 415 of our prayer book. The same day a sister will give her communion for the wished results. 2- In honour of Saint Joseph a mass will be said on the first Wednesday of the month and communion will go to him every Wednesday. On Sunday a hymn or invocation will be said to invoke the Powerful and Charitable Econome of religious orders. ASGME, EHH, Doc. 81.

It is evident that the religious calendar followed by the Grey Nuns gave primary importance to the members of the Holy Family, and thus perpetuated the heritage of Marguerite d'Youville. In addition to the aforementioned celebrations the Grey Nuns considered other important days which were significant for all Catholics: New Years Day, Ash Wednesday, the Pentecost, and All Saints Day seem to have been the most important.[1014] Unique to the Grey Nuns was the religious commemoration of Marguerite D'Youville on October 15 (her birthday) and December 23 (the day of her death). Five other days were also always celebrated and they were clearly linked to the cultural heritage of the sisters: four of these days were of major importance in the French Canadian tradition and one was part of the Irish tradition.[1015]

The daily religious life of the sisters

As in all other religious orders, the lives of the sisters were regulated by a set of rules more or less specifically stated in the order's constitution.[1016] It is known that at the EGH, in the 1890's, the time the nuns arose was around five in the morning and that in 1966 it had been postponed to five thirty.[1017] A typical day for the sisters was a meld of religious and professional duties. Based on the schedule of 1966, the only one available and most likely the most liberal, it is clear that the sisters had very busy schedules. Between 5:50 and 7:00 hours the sisters prayed and attended mass. They ate breakfast between 7:00 and 7:30 and worked until 12:00 when lunch was served. The sisters were back to work from 13:00 to 15:00 hours when they were given 30 minutes of free time. At 16:45, a few pages of the bible were read, after which a discussion of the scripture took place. Following this discussion the sisters recited the rosary until 17:30 when supper was served. At 18:40, the sisters met to pray and from 19:00 until 20:00 hours were free to talk about topics of their choice. After 20:00 silence had to be maintained until bedtime which was left the discretion of each sister.[1018] Based on this schedule, the sisters prayed at least five hours a day, and worked a minimum of eight hours since it known that "overtime" was common. It appears that the schedule was basically the same, seven days a week. However, days off, holidays, and recreational evenings did exist.[1019] In 1967, the rule was made more flexible and the sisters were allowed to arise whenever they wished as long as they attended at mass at 6:15. Silence was made compulsory after 21:00 hours which gave one extra hour for the sisters to share with their colleagues.[1020] There are no reason to believe that this schedule was different from those which would have been found in other religious orders devoted to the care of the sick.

[1013] The celebrations associated to these days and months were always mentioned in the chronicles. ASGME, EGH, Chroniques, 1895-1970.

[1014] Ibid.

[1015] The days uniquely celebrated in the French Canadian Catholic tradition were the Epiphany, Saint Catherine's day, Saint John the Baptist's day and of lesser importance Saint Blaise day. Saint Patrick's day was of course the celebration of Irish origin. It may be suggested that the lay meaning of the four French Canadian days was as important as their religious meaning. Because of this they are addressed in the chapter on French Canada.

[1016] The Grey Nuns obtained their first official constitution in 1790. The document was modified in the 1870's and further modified in the 1960's.

[1017] ASGME, EGH, Visites canoniques 1896-1953, visit of 1896; EGH, EHH, Doc 352, rules of the EGH, 1966.

[1018] ASGME, EHH, Doc, 352, rules of 1966.

[1019] Leisure activities and holidays are addressed in the chapter on French Canada.

[1020] ASGME, EHH, revised schedule, 14 March 1967.

Religion and patient care

When the EGH was established in 1895, there were thousands of Catholic hospitals in the world most of which were owned or at least administered by women who belonged to religious orders. The sisters shared a common religious heritage in which the basis for their involvement in health care could be found. These women had elected to devote their life to God and to serve Him by assisting those in need. Taking care of the sick was their way to live the Gospel. Fundamental to their involvement in health care was the belief that praying to God could be of assistance to the sick. It has also been proposed that the early involvement of Christianity in health care was linked to the "... assumption that sickness was at least partly due to sin."[1021] This old assumption was probably formed part of the basis for early religious orders' involvement in health care and certainly lead generations of Christians, and specifically of Roman Catholics believing that praying to God for forgiveness could bring recovery. It is important to note that the attribution of a causal relationship between disease and sin was not unique to early Christians and that numerous primitive societies also considered that diseases and other unexplained phenomena were due to supernatural powers.

However, in the western world, especially in the late 1800s the discovery of natural causes and of efficient treatments made less tenable the assumption that disease was a punishment of God. It is believed that these discoveries contributed to the change of focus which took place in the Catholic Church in respect of the link between God and disease. In particular, it became more common to pray God for assistance as opposed to forgiveness and the benevolence of God became increasingly the focus of the Catholic faith. The image of the good father replaced that of the punishing one. This change of focus made God the ultimate ally Who could assist those who prayed to Him, and Who could relieve humans of misery and pain. As time passed, God became more and more seen as someone who could help in times of illness.[1022] In 1962, the Catholic Hospital Association wrote: "Catholic hospitals are an integral part of the work of the Church. They are the extension of Christ's mission of mercy. [...] As Christ's love for man impelled the Church to establish hospitals, so they, in turn must serve all men in charity, regardless of race, creed, or financial status."[1023] These statements clearly show that the caring nature of God was the concept which guided caregiving in Catholic hospitals of that era.

[1021] William A. Glaser, ***Social settings and medical organization a cross cultural-national study of the hospital***, (New York: Atherton Press Inc., 1970), 21.

In general, it may be suggested that scientific discoveries had a profound impact on health care services, as well as on the daily delivery of the services rendered by the members of religious orders. In concrete terms, the proliferation of scientific medicine meant that the sisters had to develop new professional skills necessary to practice well relative to the causes and processes of disease. In addition, it may be proposed that the ever growing involvement of the state in health matters, which characterized much of the twentieth century, was also related to the emergence of the new causal relationships. Simply stated, the belief that illness was caused by supernatural forces had meant that the church or God's government on earth was best suited to deal with health care. This being the case, it is logical to put forward the hypothesis that the attribution of natural causes to the illness process opened the door for the involvement of the state or human's government; i.e "natural" government.

Although the above is useful in trying to understand some of the changes which took place in the twentieth century, it is reductionist in nature and caution is in order. Specifically, it should not be concluded that nursing religious orders only considered the supernatural aspects of disease or only the benefits they believed could come from prayer. Rather, it should be understood that they saw and continued to see the spiritual dimension of human beings as one of their essential characteristics. To them, nursing care and hospital care in general had to be holistic in nature since human beings were made of body and soul. Hence, it is not amazing that even early in this century, the sisters considered it essential to acquire the most current knowledge in terms of the biological dimension of human beings, and thus that they rapidly sought advanced education and became themselves providers of nursing education.

[1022] Yet, it must be acknowledged that the notion that disease is the result of sin never entirely disappeared. Hundreds of years of belief cannot be erased by the findings made during a few decades which is after all an insignificant period of time in the long history of humanity.

[1023] ASGME, EGH, philosophy of functions file, Catholic Hospital Association, ***Philosophy for catholic hospitals***, adopted by the executive of the CHA in June 1962.

The sisters' recognition that the soul is an integral part of human beings also explains the fact that while in western societies, the soul and the care of spiritual needs were being put aside or downplayed that they continued to subscribe to a model of care in which the spiritual dimension was central and in which they and other Catholics had a role to play. In 1986, Sister Marguerite Létourneau who was at the time Superior General of the Grey Nuns wrote:

> All the miseries Mother d'Youville alleviated along her way are prevalent today. They appear under different guises according to a particular era and culture, and yet, essentially, in the way traced by Marguerite [d'Youville], we follow Jesus who came to save us free from sickness, superstition, slavery, exclusion, rejection, poverty, and exploitation.[1024]

These words can be seen as the essence of the Grey Nuns' mission, a mission which endured over time. It was possible in the EGH papers to find statements which showed this continuity, and which indicated how the Catholic philosophy was implemented in daily patient care, and in particular, how it influenced the way in which nursing was conceptualized. It is especially evident that Jesus was the role model to follow and that nursing included a sacerdotal component.

In 1904, during her visit at the EGH, the superior general wrote the following in the canonical visits' book: "Enfin, après avoir donné aux soeurs, les avis qui m'ont semblé être les plus nécessaires, je les ai spécialement exhortées à un grand esprit de foi dans les soins qu'elles donnent aux malades; ce qui les portera à les traiter en toute circonstance avec beaucoup de charité et de patience."[1025] Similarly, in 1911, Mother Piché wrote:

[1024] Marguerite, Létourneau, SGM, Superior General, ***Les Soeurs Grises***, 65.

> "... je les ai exhortées à une très grande discrétion envers les personnes séculières avec lesquelles elles sont continuellement en contact - médecins, gardes-malades ou patients, leur recommandant d'exercer une grande charité mais aussi une grande surveillance sur les jeunes filles dont-elles ont la charge; les traitant toujours de manière à faire concevoir de l'estime pour l'état religieux mais n'épargnant rien pour les former au sérieux des fonctions auxquelles elles se préparent..."[1026]

It is obvious from these statements that the superiors wished to remind the sisters of the importance of charity and of the need to be role models for workers and patients. These visits of the superiors must have been high moments in the religious life of the sisters since they were times at which they were provided with encouragement and reminders of their special mission. Another important occasion must have been the annual retreat at which each sister was free of hospital responsibilities and thus could spend more time on her own spiritual development.

The sisters were also provided support by the hospital chaplain and members of the local church hierarchy. It is likely that the homily of the daily mass must have often included relevant topics for health care workers, and it is evident that priests offered complementary services to patients.[1027] The support and collaboration of the clergy was indeed essential to the pursuit of religious goals. It is important to note that Bishop Legal seemed to have been particularly interested in the matters related to patient care. In 1916, he published general rules for the hospitals of his archdioceses. Notably, he included specific statements about the mission of hospital sisters. He wrote:

[1025] Quote translation: "Finally, after having given the advice which seemed most appropriate, I specifically exhorted the sisters to have a great spirit of faith in the care they give to patients; this will help them under all circumstances to treat them in a charitable and patient manner." ASGME, EGH, Visites canoniques, 1896-1953, Visit of Mother Hamel, Superior General, 8 June 1904, 16.

[1026] Quote translation: "I exhorted them to show discretion with secular people with whom they are in daily contact - physicians, nurses or patients, recommending that they act according to charity but also that they closely oversee the actions of the young women who are under their responsibility; to treat them in a manner that will make them see the value of a religious life but without neglecting to inform them of the seriousness of the functions they are being prepared for ..." ASGME, EGH, Visites canoniques 1896-1953, visit of Mother Piché, Superior General, 12 August 1911, 22.

> 1- Le service de nos soeurs, dans les hôpitaux, est d'autant plus précieux que, tout en travaillant à la guérison des corps, elles peuvent encore aider puissamment le prêtre dans la **sanctification des âmes**. Elles prépareront souvent les voies de retour pour le pécheur ou le chrétien négligent; elles entretiendront les bonnes dispositions que la visite du prêtre aura commencée.
>
> 2- Elles devront s'efforcer d'acquérir, soit par l'expérience soit par l'étude, toutes les connaissances nécessaires pour remplir leur office avec la compétence voulue. Elles ne doivent point le céder, même en cela, aux infirmières laïques quelles qu'elles soient. Elles doivent l'emporter sur elles non seulement **par le motif de leur dévouement**, mais encore **par la science pratique**, car le malade qui vient à l'hôpital y vient pour y trouver la guérison, si elle est possible.[1028]

It is obvious that Bishop Legal considered that the sisters had a two-fold mission: the cure of bodies and the cure of souls. It is also strikingly apparent that in the fulfilment of her religious duties, the sister was in a similar position to the one she occupied in the professional realm. She was to assist the priest in the curing of souls, as she assisted physicians in the curing of bodies. Of importance, the words of the bishop confirm that professional competency was of primary importance if the sisters were to fulfil their roles.[1029]

[1027] ASGME, EGH, Chroniques, 1895-1970.

[1028] Quote translation: 1- The service of our sisters, in hospitals, is even more precious, since while working towards the cure of bodies they can powerfully assist the priest in the **sanctification of souls**. They will often prepare the sinners or neglectful Christians to return to religion. They will contribute to maintain the good dispositions acquired during the visit of the priest. 2- They will try to acquire, by experience or studies, all the knowledge necessary to fulfil their role with competency. They will never let lay nurses surpass them even in this, whoever could be those nurses. They must be better not only in **the motives of their service** but also in **practical science** because the patients come to the hospital to find a cure whenever such cure is possible. ASGME, EGH, By-laws and moral code file, 1915-1972: Emile Legal, OMI, ***Règlements concernant couvents et hôpitaux. Extraits des règlements, usages, et discipline de l'Archidiocèse d'Edmonton***, (Quebec, n.p., 1916), 10-11.

It is apparent from the chronicles of the EGH that the sisters took their role in the curing of souls very seriously. From 1916, the same year that Bishop Legal published the general rules, until 1967, the chronicles of December included a list of the number of patients who had returned to religious practice, had been baptized, or had joined the Roman Catholic Church. The majority of the cases listed were returns to the regular practice of religious duties. In average, there were 20 patients a year who came back to practice after having neglected this aspect of their faith. The numbers varied from year to year and except for the period of 1958 to 1967 when very few cases were listed,[1030] there were no apparent trends in the number of returns to church over time. The circumstances surrounding these returns to religious practice were also variable. Some patients returned to their religion on their death-bed, while for others it occurred prior to surgery or at unspecified times during their hospitalization. There were also a number of cases in which patients who had been married outside of the church decided to regularize their marriage while at the EGH.[1031] It certainly would have been interesting to have information about the proportion of patients who continued to practice once they were discharged from the hospital. In particular, considering human nature, one has to wonder if a significant proportion of those who returned to practice prior to surgery were more motivated by fear than faith and consequently abandoned their good intentions once danger was removed.

[1029] The importance given to professional knowledge by the Grey Nuns has been discussed in the chapter addressing the Grey Nuns as a group. Thus, only religious issues are developed in this chapter.

[1030] In general, for that period of time, there was only one case listed per year. ASGME, EGH, Chroniques, 1958 to 1967; There are probably many reasons behind the small numbers listed during these years. In particular, societal changes, the reform of the Catholic Church and the declining number of sisters present at the EGH may have contributed to the phenomena.

[1031] At least six such cases were noted. ASGME, EGH, Chroniques, 1916 to 1967.

The number of conversions a year, including a few adult baptisms, was understandably much smaller than the number of Catholics who renewed their religious commitment. Except in 1920 and 1927 when it was stated that 22 Protestants had become Catholics, there were usually five cases listed per year.[1032] The circumstances surrounding patient conversions were often similar to that of Catholic patients returning to religious practice. It must be stated that at least in a dozen of cases, some members of their immediate family were already Roman Catholics. Interestingly, five student nurses, two registered nurses and one physician became Catholics. Noteworthy, four of these individuals opted for the Roman Catholic religion after 1958. It thus appears that staff members could also have been influenced by the faith of the Grey Nuns.

It is difficult to determine the extent to which the sisters tried to convert Protestants to Catholicism. However, it may be suggested that the sisters must have been tactful in their attempts. Politically, undue proselytism could have had negative consequences for the hospital. In addition, it is believed that the sisters respected the faiths of others. For example, in 1915, internal rules stipulated that when Protestant patients wished to see a minister that one should be called as soon as possible. Similarly, the rules stipulated that Protestant nurses should assist the minister when needed and that stillborn babies should be baptized according to the proper ritual.[1033] Nonetheless, considering the central place occupied by religion in society in the early nineteen hundreds and the cleavage which existed between the Catholic and Protestant Churches, it is reasonable to propose that approaching patients about the perceived advantages of the Roman Catholic religion, and of the importance of practice for member of that church must have been common. Thus the degree to which the sisters tried to convince patients during the 1920's and 1930's must have been much greater than in later years.

[1032] Ibid.

[1033] ASGME, EHH, Doc. 98, 16 October 1915.

By the end of WW II, religion was increasingly considered a personal matter and statements written in 1945 and 1948 suggest that the sisters questioned the manner in which the issues of religion and religious practice had to be addressed with patients. For example, in 1945, the author of an article published in a Grey Nuns' newsletter stated:

> With Protestants, do not push, do not discuss ... the best way to preach is by example, patience, smile, kindness ... have prayer prepared and available for the Protestants. With Catholics it is appropriate to suggest confession before surgery ... do not insist too much about communion, do not be surprised by anything.[1034]

Similarly, in 1948, the Assistant General of the order told the EGH sisters: "We should not fear to talk about God to patients, in fact they are expecting we will, but we must be tactful and cautious. Yet, the best way by which we can save souls, is by providing a good example..."[1035]

It is believed that the changes which were introduced in the Catholic Church by Vatican II further modified and transformed the manner in which religion was incorporated in patient care. Evidence suggest that the assignment of a sister to pastoral care at the EGH in the late 1960's was directly linked to the reforms undertaken in the Roman Church. Indeed, Rome proposed that pastoral action was to become a key aspect of the mission of religious orders.[1036] According to the philosophy of the time, pastoral action was a means to live the new focus of the Church which asked that all

---

[1034] Free translation. ASGME, general files: Anonymous, ***Echo de la colline***, (St. Albert: Maison provinciale de Saint-Albert, August 1945), 4-6.

[1035] ASGME, EGH, Visites canoniques 1996-1953, Visit of Sister Sainte-Emilienne, Assistant General, 18 August 1948.

[1036] About the role of sisters in pastoral, see: Mgr Paul Grégoire, "Les religieuses dans la pastorale diocésaine" in ***La religieuse dans la cité***, (Montreal: Fides, 1968), 243-250; It should be noted that in 1967, the CHAA adopted a resolution to establish guidelines for the development of pastoral care departments in its affiliated hospitals. Castonguay, ***A mission of caring***, 92.

Catholics become witnesses of Jesus.[1037] At the heart of hospital pastoral care was the concept that a dialogue had to exist between patients, lay personnel and the representatives of the Church (sisters and chaplains). The goal was to bring reflection rather then imposing behaviours.[1038] In addition, it may be suggested that the decreasing number of sisters who worked in Canadian Catholic hospitals, and in particular at the EGH, probably contributed to the establishment of pastoral care departments soon after Vatican II. Indeed, since the religious workforce was smaller, it was important to find other means by which it would be possible to keep a Catholic philosophy. Although written in 1983, the words of Sister Bonin reflect the vision which emerged in the 1960's and which clarified the religious mission of Catholic hospitals. She said: "In my mind, there is no question here of proselytizing, there is no question of arm-twisting toward a particular expression of faith. It is simply a matter of Christian witnessing to the care of the total person; it is an active recognition of the religious nature of the person who is sick."[1039] In closing, it must be stated that the example provided by the sisters, and the ambience created by their presence may have been sufficient to bring patients to reconsider the value of faith in their life. Behavior is often more convincing than words. In the early days of the hospital, when cures were relatively rare and when the duration of hospitalization was likely much longer than at later times, it can be suggested that the quiet presence of a group of sisters may have in itself provoke spiritual questioning.

Charity

Based on their religious beliefs, owners of Catholic hospitals usually considered that poor people should not be refused treatment because of their financial status.

[1037] Nive Voisine, ***Histoire du catholicisme québécois***, Tome II, (Montreal: Boréal Express, 1984), 271.

[1038] Normand Perron, ***Un siècle de vie***, 248-249; The institution studied by this author also created a pastoral care department in the 1960's.

[1039] ASGME, EGH since its foundation, Doc. 38, Address given by Marie Bonin SGM, at an appreciation diner for the EGH staff, which took place at the Grey Nuns Regional Centre, on February 4, 1983.

Further, it was part of the religious mission of the sisters who were often in charge of these hospitals to assist those in need even if they were not hospital patients. In the case of the Grey Nuns, assisting the poor was specifically a characteristic of the order, which was part of the legacy of Mother d'Youville. The EGH annual reports of 1913 to 1967 show that the nuns regularly assisted those in need. For hospital patients the assistance took three forms: free consultations, free treatments, and free prescriptions.[1040] In 1918, a record number of 1,089 patients received free consultations. Usually, the number of free consultation was more around 200 a year. After 1952, free consultations were no longer listed. Instead, the records listed free treatments and free prescriptions. The number of free treatments ranged between 17 and 120 a year, and on average 48 free treatments were given yearly. Between 1952 and 1957, an average of 1,172 free prescriptions were donated every year. It must be noted that after 1959, the annual number was never more than 80. This decrease may have been a side effect of the new hospital insurance act which covered medications taken while hospitalized. It was interesting to note that after 1959, the sisters increased the number of donations in kind. In the early 1950's, the number of this type of donations ranged between 170 and 300 a year, while after 1958 it was consistently above 1,100 a year. It is not known who were the beneficiaries of these donations, but it is likely that local paupers would have been the main recipient of such charity.

The main charity for people who were not patients of the hospital consisted of free meals. It appears that the number of meals given was a function of the economic climate. The highest number of meals for a single year was given in 1931 when 9,000 free meals were distributed, while the lowest number occurred in 1960 when only 52 meals were served.[1041] In average 1,732 meals were given annually. Finally, the records occasionally included the number of families who received help and the number of home visits done by the sisters. In both cases the annual numbers ranged between 5 and 30 a year, while the mean was around 10 cases. However, for these two types of services, the numbers are less meaningful than in the previously discussed donations. For example, these numbers do not provide information about how the families were assisted or about qualitative information concerning home visits. In other words, detailed reports about the assistance provided to families would have been much more indicative of the work done by the Grey Nuns. Unfortunately, this type of data was unavailable. Nonetheless, taken as a whole the recorded information on charitable services shows that the sisters tried to help patients and individuals outside of the hospital and this, even at times when their own resources were more limited.

[1040] Recording of these free services was not always consistent. For unknown reasons statistics about these services were not recorded between 1941 and 1947. However, for all other years, partial or complete data was always available.

[1041] The number of meals given in 1939 was phenomenal considering the financial situation of the EGH at that time. It must be noted that the sisters did not give any meals in 1936 and 1937. The annual reports included a statement to the effect that the city had

Religion and lay nurses

As members of a religious order, the sisters combined their religious and professional roles and these roles were integrated in a holistic vision of humankind. Data presented in the School of Nursing chapter also indicated that the sisters wished to transmit their holistic philosophy to student nurses. It follows that their aim was to prepare nurses who during their professional careers would continue to practice according to this philosophy. It has been noted by Petitat, that in Quebec where most schools of nursing were in Catholic hospitals it was common practice until the late 1960's to use religious metaphors to describe nursing and to compare the profession to the priesthood.[1042] Petitat presented a number of instances where the linkage between nursing and the priesthood was depicted and emphasized. For example, he reported that in 1959, Cardinal Léger said to an audience of nurses: "La vocation de l'infirmière s'identifie en plus d'un point à celle du sacerdoce. Vous touchez du doigt, pour ainsi

---

asked them to interrupt this practice. It is likely that municipal authorities considered that offering food to the poor, even if well intended, increased the problem since the people who were thus fed may have elected not to ask for municipal assistance which would have distorted statistics about poverty and consequently made it more difficult to obtain assistance for higher levels of government.

[1042] Petitat, ***Les infirmières***, 306.

dire, le joint entre l'âme et le corps de vos malades ..."[1043] Similarly, and as late as 1973, the director of a school of nursing (who was not a sister) declared to a women journalist that: "You know Miss, I do not have time to think about men, being a nurse is similar to being in the priesthood, all energy must be devoted to patients."[1044] Petitat recognized that not all nurses would have described their profession in such a way. However, for him the essential thing was that many people (not to say most) believed that nursing was a special profession whose members had to display an attitude similar to that required for priesthood or, by extension, sisterhood.[1045]

Considering the minority status of Catholics in Alberta, it is unlikely that Albertans in general would have compared nursing to the priesthood to the same extent as Quebecers did. However, within the world of a Catholic hospital in Alberta, it may be proposed that statements made about nursing might have resembled those which were made in Quebec. Indeed, evidence suggests that at the EGH in 1957, nursing was described in a similar manner. At that time, the definition of nursing included in the *Nursing Procedures Manual* was:

> Nursing is an art based on scientific principles. It is that service to the individual which help him attain or maintain healthy states of mind, body and soul, or when a return to health is impossible, the relief of pain and discomfort. It includes an understanding of the sick person and his needs and a real attempt to help him disentangle his problems whether they be economic, social, physical or spiritual, in the light of all the best available knowledge.[1046]

This definition shows that as expected, nursing was defined through a holistic approach to the person, which included their spiritual needs. However, of great significance is the fact that the definition of nursing was followed by this poem:

[1043] Quote translation: "In many aspects the vocation of nursing is similar to the priesthood. It can be said that you touch the link between the soul and the body of your patients." Ibid., 308.

[1044] Free translation. Ibid., 309.

[1045] Ibid., 306-311.

[1046] ASGME, EGH, Nursing Procedures Manual, 1957, ii.

God made a nurse:
God made a nurse;
He made her heart brave, true and kind
And like the mountain streams her mind
As crystal clear, yet smooth and deep
As where the waters rush and sweep
He made her hands strong, tender, skilled
There touch with His own pity filled,
He gave to make His nurse complete
A sense of humor, wholesome, sweet
God made a nurse - - - Thank God![1047]

This poem has many interesting aspects. It can be noted that the ideal nurse portrayed in this poem is described in a holistic fashion since her soul (her heart), her mind and her body (hands) are mentioned. Taken as a whole the poem suggests that nursing is a special field of work. In particular, the fifth line conveys the message that the presence of God is known through the nurse's work, that is, through her He brings His mercy to those in need of care.

Although it is difficult to assess the degree to which the lay nurses who worked at the EGH adhered to this conception of nursing, a reasonable number of Catholic nurses must have been proponents of or at least not opposed to the Church views. The chronicles show that nurses had "Catholic action" meetings and that religious retreats were organized annually for the nursing staff.[1048] In addition, according to the chronicles, in the 1950's some nurses belonged to a Catholic association of nurses. Unfortunately, it was impossible to establish the number of members and type of activities of that group.[1049]

[1047] Ibid.

[1048] ASGME, EGH, Chroniques, 1930 to 1950.

Of interest, the *Nursing Procedures Manual* of 1957 included seven pages devoted exclusively to religious matters.[1050] This section of the manual was divided into three sub-sections: "The Roman Catholic faith", "The Jewish faith" and "Protestants and other religious groups". Significantly, the general introduction read as follows: "To meet the spiritual needs of the patient adequately, the nurse needs some understanding of the requirements of the different religious faiths."[1051] It is thus clear, that in the 1950's, the spiritual needs of non-Catholics had to be understood. In fact, it may be suggested that ignoring the faith of others would have been contrary to the sisters' holistic philosophy and approach to humankind since, if it had been the case, the spiritual needs of a large proportion of patients would have been ignored.

The sub-section on the Catholic faith included a number of details about the chaplain's role and about the manner in which the nurses were supposed to assist him. In particular, it indicated that the chaplain paid a daily visit to all Catholic patients and that nurses were to call him when a patient was scheduled for a major surgery, when a patient was seriously ill, when a patient or relatives asked to see him, and when a patient died suddenly without receiving the sacraments. Nurses were also expected to provide the chaplain with a daily list of the patients who wished to go to confession or wished to receive communion. Finally, the sub-section also included a description of the procedures to follow for extreme unction and for the baptism of newborns whose life was in danger.[1052] The sub-section about the Jewish faith included a description of the role of the rabbi, of how to prepare a room for the circumcision of male newborns, of the significance of the Sabbath[1053], and of the dietary regulations followed by Jewish people.[1054] The sub-section devoted to Protestants and other religious groups was very succinct. It only recommended that whenever possible a minister of the patient's own faith should be called and it provided a description of the items needed for baptism and communion.[1055] It is essential to state that spiritual needs were also mentioned in other sections of the manual. For example, the sections on preoperative care, postoperative care and the dying individual all included statements about the importance of ensuring that spiritual needs were met.[1056] Based on the results presented in this section, it is clear that nurses were expected to provide spiritual assistance or to make it available to patients.

[1049] Ibid., 1952.

[1050] ASGME, EGH, Nursing Procedures Manual of 1957, 171-176.

[1051] Ibid., 171.

[1052] Ibid., 171-174.

The Catholic morals

By virtue of its status as a Catholic hospital, the EGH had specific regulations which were based on the principle of sanctity of life which is one of the most important tenets of Catholic morals. Sanctity of life means that only God can give life and that He is the only One who can decide when to take it back. Therefore, surgery or other medical acts violating this principle were prohibited. Specifically, it meant that abortions were condemned, while sterilization could be performed only if it was necessary to save the life of woman who was not pregnant.[1057] The mention of pregnancy was included because under Catholic rules, the life of the child to be always assumed priority over all else. In other words, when the life of the mother and child were both in danger and only one could be saved, caregivers were to select the child.[1058] It seems that Bishop Legal was particularly concerned about ensuring that Catholic morals were respected in hospital caserooms. In 1915, he wrote to the EGH Superior to request that a sister be always present in the caseroom, since it would deter those who might be tempted to transgress Catholic rule. However, it is important to note that he concluded his letter by stating that his purpose was to provide guidance to the sisters and that his letter was not based on the belief that rules had been transgressed at the EGH.[1059]

[1053] Included was the recommendation to postpone all treatments and procedure normally scheduled for that day when possible.

[1054] ASGME, EGH, Nursing Procedures Manual of 1957, 175.

[1055] Ibid, 176.

[1056] Ibid., 154, 160 and 177.

[1057] ASGME, EGH, Bylaws and moral code file, 1915-1972: Legal, ***Règlements concernant couvents et hôpitaux***, 10-13.

Available data about abortion suggests that Catholic morals were respected and accepted by those who worked at the EGH. Indeed, it was possible to find only two statements indicating that physicians had wished to use the EGH facilities to perform abortions. In one case, a physician was refused access to the operating room after having attempted to abort a patient. Following the event he decided to leave the EGH.[1060] Similarly, another physician who had not been granted the permission to do this procedure decided to no longer send his patients to the EGH.[1061]

Significantly, data suggests that the sisters sought legal counsel when new legislation could potentially affect the enforcement of Catholic morality in the hospital. For example, following the proclamation of the Alberta *Sexual Sterilization Act* in 1928, the superior met with a group of sisters and physicians to discuss the issue and it was decided to seek clarification from the minister of health.[1062] Needless to say the sisters were opposed to any law which made compulsory or permitted the sterilization of individuals. Similarly, in 1969, legal advice was sought in respect of amendments to the national criminal code which made abortion more accessible to women. Prior to these amendments, abortion had been lawful only in cases where the physical health or life of a woman was threatened. The new rules meant that a threat to mental health was sufficient to justify an abortion. Based on these changes, the hospital lawyer informed the EGH administration that the amendments did not force hospitals to perform abortions but that it would be advisable, because of legal precedents in the United States, to inform mothers denied abortions which city institutions offered the service.[1063]

[1058] Ibid., 12.

[1059] ASGME, EHH, Bishop Legal to Sister Bissonnette, 13 August 1915.

[1060] ASGME, EGH, Chroniques, October 1921.

[1061] Ibid., April 1932.

[1062] Ibid, 15 April 1928. The eugenics movement which demanded the compulsory sterilization of "feeble-minded" individuals was active in Alberta as early as 1905. Palmer and Palmer, ***Alberta a new history***, 183; The Sexual Sterilization Act of 1928 responded to the demands of the eugenics movement by imposing sterilization to "mentally defective" patients. Government of Alberta, ***Statutes of Alberta***, Edmonton: King's printer), 117-118. Of interest, eugenics laws continued to exist in alberta until the mid 1970's when the Lougheed government abolished them.

Religion and physicians

The chronicles revealed that the sisters usually organized a supper and mass for physicians on the anniversary of St. Luc.[1064] This day was undoubtedly selected because St. Luc was considered the saint patron of physicians. It is relevant to state that it does not seem that physicians historically became involved in annual retreats as was the case for nurses. Interestingly, in 1953, after the death of Dr. Fortier and Dr. Clare the hospital radiologist instituted the "Fortier Mass". From then on, Catholic physicians attended a monthly mass held in the hospital chapel.[1065] The chronicles revealed that 28 of the 35 Catholic physicians practicing at the EGH in 1953 chose to participate in this religious activity.[1066] Based on this information and on the fact that transgressions of Catholic morality seemed rare, it may be suggested that physicians contributed substantially to the Catholic ambience of the EGH.

In conclusion, it has been seen that the EGH sisters patterned their religious life on the spirituality of Mother d'Youville. Significantly, their views on patient care and charitable service were based on a heritage of centuries of involvement of the Catholic Church in hospital care. To some degree, their religious mission was determined by the place they occupied in the Catholic hierarchy. As nuns they were to assist the priest in the services he rendered to the sick. Lay nurses and physicians were also asked to render their professional services in the spirit of the Roman Catholic heritage. Of importance, the official conceptualization of nursing was based on a holistic view of human beings from which it followed that nurses had a duty to participate in the fulfilment of patients' spiritual needs. It does not seem that physicians were asked to contribute to the daily fulfilment of these needs. However, their practice had to reflect Catholic morals and as such they were to practice within the limits imposed by the Roman Church.

[1063] ASGME, EGH, Board of directors meeting, 24 October 1969. Letter of Lucien Maynard to Gordon Pickering, Executive Director of the EGH, Edmonton, 17 October 1969.

[1064] ASGME, EGH, Chroniques, 1895-1970.

[1065] Ibid., 1953 to 1970.

[1066] Ibid., 6 November 1953.

It is difficult to describe in words the Catholic ambience which existed at the EGH. The effect of this ambience on patients' spiritual lives is even more difficult to assess. Results presented in this chapter provide a skeleton of evidence based on written records which were preserved over time. Relying on such records may perhaps hold a number of limitations in addressing the topics of religion and faith than it has in discussing any other topics presented in this research project. The abstract nature of religious faith makes it a daunting task to measure the role it played in patient recovery. Needless to say, the effect of prayers cannot be measured like the effects of antibiotics or other material means of treatment. However, it is reasonable to suggest that for those who believed in God, the services provided by the sisters, chaplains and employees may indeed have had a thoroughly therapeutic effect.

CHAPTER 16

THE GREY NUNS, THE EGH, AND THE FRANCO-ALBERTAN COMMUNITY

The purpose of this chapter is to examine the links which existed between the Grey Nuns and the Franco-Albertan community of Edmonton and the place occupied by the EGH in that community. The results presented in this chapter show that the Grey Nuns lived what could be labelled "a French Canadian life". Evidence suggests that the Franco-Albertan community was attached to the EGH and that the sisters were confronted with some of the problems experienced by the Franco-Albertan population in general and that the nature and beliefs of that population influenced the degree to which the hospital was able to provide services in the French language. This chapter is divided into three sections: the social life of the Grey Nuns, the Franco-Albertan staff of the EGH, and the Franco-Albertan question at the EGH.

The social life of the Grey Nuns

Although the Grey Nun's daily schedule was filled with religious and professional activities, the sisters had a rich social life that must have greatly contributed to their general well-being. It is important to understand that when a young woman joined the Grey Nuns' Order she was adopted by a new family made of numerous sisters. Convent life required the ability to adapt to living with strangers and to develop a reasonable level of tolerance to group living. However, this type of living also had advantages including the availability of companions with whom important days could be celebrated and with whom it was possible to participate in social activities on a regular basis.

Festive days

As demonstrated earlier, the majority of the EGH Grey Nuns were French Canadians. Thus it is not surprising that the sisters' calendar of important days was French Canadian in nature. The data presented in this section shows that they celebrated these days according to the rites and customs found in French Canada.

Christmas

Until Vatican II, the sisters usually attended three masses on Christmas Day.[1067]

[1067] ASGME, EGH, Chroniques, 1895 to 1965.

This practice was also common for lay Roman Catholic French Canadians.[1068] After Vatican II the number of masses was reduced to two and normally one was conducted in French while the other was sung in English.[1069] During the entire history of the EGH the sisters followed the custom of having a *Réveillon* which took place after midnight mass. In French Canada, the *Réveillon* is a very important custom which consists of eating a full Christmas dinner and celebrating until sunrise.[1070]

New Year's Day

Until the 1950's, Christmas was primarily a religious holiday while the New Year's holiday was the family event of the year. Noteworthy, French Canadians did not give Christmas gifts. Instead presents were offered on New Year's Day. The New Year was usually celebrated with grandparents and the entire extended family. New Year's Day was particularly important for the French Canadians of western Canada. Most of them had left dozens of relatives in eastern Canada and this probably explains why until the 1950's they coveted the honour of being the first person to wish Happy New Year to other members of the community.[1071] Based on the EGH chronicles it appears that the Franco-Albertans of Edmonton cherished that tradition and visited the Grey Nuns after New Year's mass.[1072] The French Canadian parishioners of Saint-Joachim, the Knights of Columbus, and the French Canadian physicians returned year after year to give their seasonal wishes. Members of other religious orders such as Franciscans, Oblates and Faithful Companion of Jesus were often among the visitors of New Year's morning. Remarkably, very few women's name were listed in the enumerations of visitors. Undoubtedly, they were too busy in their kitchens to be able to make these traditional visits. Little was found about the other activities of the sisters on New Year's Day. However, in 1947 the chronicles recorded that they had spent the evening singing French Canadian Christmas carols and traditional songs[1073], and in 1962 shared a "French Canadian Evening" with the Sisters of Misericordia.[1074] Based on this information it may be suggested that the sisters had a fairly typical New Year's evening.

[1068] Normally the three masses were at midnight, five-thirty and nine in the morning. Jean-Claude Dupont and Jacques Mathieu, ***Héritage de la francophonie canadienne, traditions orales***, (Sainte-Foy, Quebec: Presses de l'Université Laval, 1986), 19.

[1069] ASGME, EGH, Chroniques, 1966 to 1970.

[1070] Today, Christmas presents are usually opened before dinner is served.

[1071] Dupont and Mathieu, ***Héritage de la francophonie canadienne***, 26.

[1072] The chronicles revealed that after 1960 the tradition disappeared with the exception of French Canadian physicians who continued to visit on New Year's morning. ASGME, EGH, Chroniques, 1960 to 1970.

Epiphany

Like their ancestors from France, French Canadians celebrated the epiphany by making a special cake in which were hidden a dry pea and a dry bean. The two persons who found the pea or the bean in their piece of cake were proclaimed the queen and the king and consequently were given the privilege of establishing the evening's agenda.[1075] The chronicles revealed that the sisters always celebrated epiphany in this manner.[1076] However, the Grey Nuns' tradition also included a religious component. Pieces of paper bearing the name of each sister were put in a hat, and the sister whose name was drawn received "charity". This meant that at the mass of the following day all sisters prayed for the well-being and happiness of the sister who had been granted charity.[1077]

Saint-Blaise's Day

Religious rituals often have their roots in cultural characteristics that developed through time because of the environment in which the believers lived. Such was the case of the "blessing of the throats" which occurred on Saint-Blaise's Day (February 3rd) in the churches of Quebec, and in the chapel of the EGH. The custom was linked to the hard winters which brought winter ailments often accompanied of sore throats. It was thus logical that once a year in the midst of winter, parish priests asked God to protect his followers from seasonal diseases. The extent to which this practice was common in Alberta could not be determined. However, it is known that Franco-Ontarians received a similar blessing on the 6th of January.[1078]

[1073] Ibid., 1 January 1947.

[1074] Ibid., 1 January 1962.

[1075] In French the three wise men are referred to as the three kings. This explains the association made between royalty and epiphany.

[1076] ASGME, EGH, Chroniques, 1895 to 1970.

[1077] Ibid.; The explanation of the meaning of "receiving charity" was provided by Sister Fernande Champagne, archivist of the ASGME.

Saint John the Baptist's Day

Like their first ancestors from France, the French Canadians of lower Canada always celebrated Saint John the Baptist's day. However, the ritual bonfires that accompanied the celebrations began to take a different meaning in the turbulent political times of the 1830's.[1079] On June 24, 1834, Ludger Duvernay, a patriot, founded *La Société Saint-Jean Baptiste* and proclaimed that *Saint-Jean Baptiste* should be patron saint of French Canadians. The society was definitely political in spirit since its goals were to protect the French Canadian institutions, language and laws. Within a few years, branches developed in every regions of Lower Canada.

After Confederation, the society began to be active outside Quebec, including the City of Edmonton where a branch was created in 1894.[1080] For the next three decades *La Société Saint-Jean Baptiste* was a key association for Franco-Albertans. The Saint-Joachim parish was always a site of celebration where typical activities included a mass, a banquet and the presentation of a play.[1081] The Grey Nuns participated in these activities and collaborated with the Oblate Priests of Saint-Joachim. For example, in 1928, the sisters helped them to prepare the menu for the picnic of June 24 and the hospital kitchen was used to cook hams that had been purchased by the society. The chronicles also stated: "We are happy to show our patriotism and to help the good Oblates."[1082] After the decline of the society, the celebrations of Saint-John the Baptist Day became less important in Edmonton.[1083] However, the sisters always continued to celebrate the event. In particular, they often took a day off and had a picnic on the hospital grounds.[1084] It is thus evident that for them *La Saint-Jean* continued to be an important event.

[1078] In that province the custom also included the blessing of candies which after the ritual were said to often acquire miraculous properties and thus were distributed to children every time they developed a sore throat. Dupont and Mathieu, ***Héritage de la francophonie canadienne***, 30.

[1079] The 1830's were marked by political agitation in both Lower and Upper Canada, where leaders such as Louis-Joseph Papineau and William Lyon Mackenzie claimed that the Britain should give more autonomy to its North American colonies. Unrest peaked during the rebellions of 1837 which to some degree contributed to the birth of the Canadian Confederation in 1867.

[1080] Hart, ***Ambitions et réalités***, 33.

Saint-Catherine's Day

When the first French settlers came to Canada the also brought the custom of celebrating Saint-Catherine's Day (November 25) which was considered the feast of all women who remained single after their twenty-fifth birthday.[1085] In the 1660's Marguerite Bourgeois, the founder of the *Congrégation de Notre-Dame*, an order devoted to the education of children, established the tradition of making molasses candies as part of the festivities. Since then, every year on November 25 elementary school pupils learn how to make *la tire Sainte-Catherine*. Like all French Canadians the Grey Nuns followed the custom of making *la tire* and as single women they found the day particularly relevant to their status. The chronicles often referred to it as the sisters' birthday.[1086]

[1081] ASGME, EGH, Chroniques, 1915 to 1928.

[1082] Ibid., 24 June 1928.

[1083] The economic depression of the 1930's, the effect on the local French speaking population of the conscription crisis of WWII, and the increasing assimilation are frequently seen as factors which contributed to the decline of celebrations. However, since the 1980's Franco-Albertans are renewing the traditions.

[1084] It must be noted that June 24 had become a statutory holiday in Quebec. ASGME, EGH, Chroniques, 1932 to 1970.

[1085] Saint-Catherine was a virgin martyr who died on November 25, 307 A.D.

Regular leisure activities

The chronicles revealed that the sisters had a number of leisure activities, which most often took place in the evening. Birthdays were also regularly celebrated and group activities were a part of their regular life. It appears that many evenings were spent singing together, watching movies, and playing cards and parchesi. Although a large proportion of the movies were religious in nature[1087] popular cinematography was also seen and enjoyed. However, the playing of cards was adapted to religious life. The sisters played with special card decks bearing religious figures and cardinal virtues instead of the regular, king, queen, jack, spades, hearts, diamonds and clubs. The games played were the same as those played with ordinary cards but their names were also religious. For example, the sisters played the games of *perfection* and of *monastery* which resembled the game of eight.[1088]

Outdoor activities also existed in both winter and summer months. In the winter, there were always some sisters who skated regularly, and sleigh rides were occasionally organized at St. Albert.[1089] However, as was the case for other women, the practice of sports became much more common after 1950. By that time the sisters had their own skating rink in the winter months which was transformed into a tennis court when summer arrived. Roller skating was regularly practiced, undoubtedly by the younger sisters, and in 1965 four sisters enrolled in swimming lessons at one of the local pools. Being allowed to take swimming lessons with lay women reflected the changes which were taking place in religious orders, particularly in respect of clothing regulations.[1090]

It is important to note that the sisters enjoyed summer holidays, called the

---

[1086] ASGME, EGH, Chroniques, 1895 to 1970.

[1087] Common topics were the life of saints, Christ's life, and missionary work.

[1088] Personal communication with Sister Fernande Champagne, archivist.

[1089] ASGME, EGH, Chroniques, 1895-1970.

[1090] The Grey Nuns adopted modern clothing in 1967. Ibid., May 1967.

Chateaugay. This word was used because Mother d'Youville established the tradition of sending the sisters spend a few days of rest at the farm of Chateaugay (an island near Montreal). Interestingly, in 1930 a little cottage was built in the backyard of the EGH and until the 1950's this small house was often used as a summer holiday retreat. Significantly, in 1963 the Sisters of Misericordia offered the Grey Nuns free usage of their *Lac Sainte-Anne* cottage for two full summer weeks. The following year the Provincial Council rented the Salesian Brothers cottage for two weeks and in 1965, the Grey Nuns decided to build their own facility at *Lac Sainte-Anne*. From then on, the sisters usually spent part of their summer holidays at that location. Sunday picnics were also common during the warm season and St. Albert and Whitemud Creek were regularly selected for this activity.[1091]

Finally, it is important to mention that in April 1970, the sisters moved to four apartments located in the neighbourhood of the hospital . At the time, they immediately realized that this new housing arrangement would alter their community life. It was thus decided that once a week all sisters would spend an evening together and take that time to discuss spiritual matters.[1092]

Social activities with other religious orders

The chronicles showed that the Grey Nuns always entertained links with other French Canadian or French religious orders. Not surprisingly, it was also found that a closer relationship developed with the Sisters of Misericordia, another French Canadian nursing order. In general, social activities with outsiders were much more common after 1950. This tendency was probably linked to the fact that the number of sisters was much smaller than in previous decades and that the softening of the rules which regulated religious orders facilitated contacts between orders. As seen earlier, the reduction of the number of sisters who worked at the EGH led to a greater delegation of responsibilities to lay individuals. In turn, it is logical to suggest that this greater delegation led to a decrease in the number of hours of work, thus increasing the number of hours which could be devoted to social activities. In addition, it may be suggested that in itself, the reduction of the number of sisters probably facilitated the sharing of social activities with members of other orders especially since they were also much smaller than they had been in the past. For example, it hard to imagine how 30 sisters could have regularly invited for supper another group of 30 sisters. In contrast, ten sisters inviting another group of similar size seems much more feasible. It is possible that the reduction in size also increased the need to socialize with outsiders since a smaller number reduced the likelihood of finding others with similar interests.

[1091] ASGME, EGH, Chroniques, 1920 to 1970.

[1092] Ibid., 6 April 1970.

1895 to 1950

During this period of time, the chronicles revealed that members of other religious orders or dignitaries of the Roman Catholic Church who were passing through Edmonton often stopped at the EGH.[1093] This information suggests that the Grey Nuns welcomed their visitors well. However, it was found that during these decades the sisters shared few social activities with members of other orders. The only regular activity regularly mentioned consisted of going to the annual play staging the students of the Edmonton Jesuits' College. Noteworthy, the sisters were always officially invited by the Jesuit Priests who were in charge of the school. The chronicles indicated that during that era, the Grey Nuns, the Sisters of the Precious Blood, and the Faithful Companion of Jesus usually exchanged seasonal gifts such as fruit cakes, grapefruits, and Easter eggs.

1950 to 1970

During these twenty years, the Grey Nuns were usual guests of the Oblates who invited them to the plays presented by the students of *Collège Saint-Jean*. Students of the *Collège* seemed to appreciate the company of the Grey Nuns since they often brought movies and stayed to view them with the sisters. Interestingly, it does not seem that the Grey Nuns had very strong links with *Les Soeurs de l'Assomption* (also a French speaking order) who operated a private school for girls in Edmonton. It may be suggested that links were easier to establish within another nursing order since professional affinities already existed. This may in part explain why the Sisters of Misericordia and the Grey Nuns tended to socialize together. The sisters invited each other for birthday parties, afternoon teas, suppers and social evenings at which the sisters often sang and watched movies. The chronicles of September 8, 1954, suggests the importance of these events: "These family like events tighten the friendship which exist between the two orders."[1094]

[1093] For example, Bishop Joussard visited in 1922, and Cardinal Villeneuve was welcomed in 1936. ASGME, EGH, Chroniques, 1932 and 1936.

The Franco-Albertan staff of the EGH

Data presented in previous chapters indicated that many nursing students were Franco-Albertans and that a large proportion of the early union leaders of the support staff were often of this nationality. Although exact numbers could not be determined, further evidence suggest that many Franco-Albertans worked at the EGH. In particular, the chronicles regularly mentioned marriages, deaths and births of children of Franco-Albertan employees.[1095] A partial staff list suggests that in 1969 at least 75 members complement of personnel were Franco-Albertans.[1096] At face value this seems like a small number. Nevertheless, it is quite important considering the size of the Franco-Edmontonian community at the time.

It has already been stated that Franco-Albertan physicians often chose to practice at the EGH. Significantly, they were always well represented in leadership positions. As late as 1954, three of the six physicians who constituted the medical executive committee were from that nationality. It is relevant to acknowledge that Dr. Louis-Philippe Mousseau, who practiced at the EGH from 1934 to 1962, was an exceptional leader who significantly contributed to accomplishing the mission of the EGH. It has been already shown that he was an ardent supporter of the local Grey Nuns when they experienced difficulty. The expertise of Dr. Mousseau was also recognized by his medical colleagues. In particular, he was chief of surgery, chief of the medical staff for a number of years, was assistant clinical professor of surgery at the University of Alberta, for three years served on the Board of Governors of that institution. Dr. Mousseau was also elected President of the national French Canadian association of physicians in 1955, and received two honourary doctoral degrees from the *Université de Montréal* and the *Université Laval*.[1097]

[1094] Ibid., 8 September 1954.

[1095] ASGME, EGH, Chroniques, 1895-1970.

[1096] The surname was used to identify these individuals. Married women who had French surnames were not included since in such case, surnames would not have been reliable indicators of nationality. ASGME, EGH, Board of Directors papers, 1969.

Significantly, Dr. Mousseau was also actively involved in *L'Association Canadienne-Française de l'Alberta* (ACFA). He was President of the Association from 1945 until 1952, during which time the first French speaking radio station of Edmonton was created.[1098] This involvement explains in large part why Dr. Mousseau always tried to attract French Canadian physicians. However, he was obviously not alone in this crusade since in 1965 (three years after his death) the physicians in charge of intern recruitment wrote personal letters to professors of medicine of the Université de Montréal and the *Université de Sherbrooke* in order to try to attract interns from these French speaking institutions.[1099] Although the outcome of their appeal could not be determined, it is certain that a number of physicians definitely wished to preserve what remained of the French character of the EGH.

In closing, this section it is of interest to mention that when the sisters undertook constructions or renovations that they regularly hired French Canadian contractors.

[1097] This information is taken from excerpts of the address delivered by Lucien Maynard at the unveiling of a painting of Dr. Mousseau a few months after his death. The Grey Nuns had this painting made by the same Montreal painter who had drawn a portrait of Mother d'Youville for her beatification. ASGME, EGH, Chroniques, 18 December 1963.

[1098] ASGME, EGH, Chroniques, 25 January 1952; After 16 years of lobbying the French station CHFA began to broadcast on November 21, 1944. Ibid.; Allaire, "Pour la survivance," 86.

[1099] ASGME, MMEM, Report of the interns' recruitment committee, 3 May 1965.

Similarly, the sisters usually had French speaking legal advisors, and insurance agents.[1100] Thus, it may be suggested that the EGH also provided work for Franco-Albertans who were not regular employees.

The Franco-Albertan question at the EGH

It has been stated that between 1895 and 1970, the ratio of the number of Franco-Albertans to the total population of Edmonton and Alberta significantly declined. The minority status of Franco-Albertans was multifold since they were a linguistic and religious minority, and further the language they spoke made them a minority within the Roman Catholic minority. Data presented earlier showed that language and religion question came into play at the EGH. The purpose of this section is to provide further evidence indicating that the Grey Nuns were concerned about issues surrounding the destiny of the French speaking population, and that they also confronted issues directly related to their minority status.

Until the 1960's, French Canadians considered that language and religion were interdependent and that losing one would result in the loss of both. Thus, the protection of French was essential to the protection of the Catholic faith. The nationalism of French Canadians was centered around these two aspects of their identity, and it may be suggested that this was a natural inclination since both characteristics were regularly under attack. It is thus not surprising that regaining the right to be educated in French became the key political issue of Franco-Albertan associations and in particular of the ACFA.[1101] Created in 1926, the ACFA had two general objectives which were to ensure the survival of the Franco-Albertan community and to foster unity among the members of this community.[1102] The creation of an association such as the ACFA was seen as necessary, especially since the older elite (not born in Alberta) was disappearing and since many members of the younger generation who had been raised in the culturally mixed environment were assimilating to the dominant culture.[1103] It is also possible that the replacement of French speaking with English speaking priests after the nomination of Bishop O'Leary may have contributed to increasing the Franco-Albertans' awareness that they were in a precarious situation.

[1100] ASGME, EGH, Chroniques, 1895 to 1970.

[1101] During the territorial era, the residents of the Northwest Territories had been able to operate schools where the language of instruction was French. However, in 1905, this right was limited to one hour per week and only during the first two years of elementary school. Smith, "A history of French speaking Albertans", 92; In 1925 , a small victory occurred when the province allowed the teaching of one hour of French per day in both elementary and secondary schools. Hart, ***Ambitions et réalités***, 139-140; In 1968, Alberta permitted the establishment of bilingual schools where 50% of the classes could be taught in French. Allaire, "La survivance", 80. For details about the strategies and campaigns which were used by Franco-Albertan teachers to maintain a greater presence

The Grey Nuns, nationalism, and the ACFA

The chronicles of the EGH show that the Grey Nuns were concerned about the future of the Franco-Albertan community. For example, in October 1923, it was stated that the Order had agreed to send some sisters to establish a school at Legal "... a nice parish whose national future was in danger." [1104] Naturally, the request had been made by the curate of Legal who stated that he wanted Grey Nuns as teachers because he knew they would be able teach French.[1105] It is impossible to establish the extent to which the sisters espoused national causes. However, it is evident that a number of them were worried about the situation. For example, in 1927, the chronicles stated:

---

of French was permitted see: Anne C. Gagnon, "The Pensionnat Assomption: religious nationalism in a Franco-Albertan boarding school for girls, 1926-1960," (Master's of education thesis University of Alberta, 1988).

[1102] Although funded in 1926, a provisional executive had been established in 1925. This nine people executive included Dr. J.E. Amyot and Dr. A. Blais who both practiced at the EGH. John Edward Hart, "The history of the French-speaking community if Edmonton, 1795-1935," (M.A. thesis, University of Alberta, 1971), 158; Allaire, "la survivance", 68.

[1103] Hart, "The history of the French-speaking community of Edmonton", 144.

[1104] ASGME, EGH, Chroniques, October 1923.

[1105] Ibid.

"Notre belle langue est menacée depuis que l'autorité épiscopale est devenue anglaise."[1106] Similarly, on June 24 1946, the sisters asked Saint John the Baptist to protect their faith and language.[1107] In 1945 the Grey Nuns' provincial newsletter stated that a number of sisters had listened to the excellent radio speech of Madame L.Roy who addressed the topic of national patriotism. In essence she urged French Canadian mothers to transmit the French language to their children and to ensure that they were raised in the Roman Catholic faith.[1108] It also appears that EGH sisters were regularly delegated to the annual ACFA general meetings.[1109] It does not seem that any sisters ever held leadership positions in the Association. However, their presence at meetings suggests that they supported the efforts of the organization. The reliance of the sisters on some of the leaders of the Franco-Albertan community also suggest that they realized the importance of unity and the advantages which could be gained from this unity. For example, it may be suggested that the presence of Premier Manning at a fund raising event of 1954 was advantageous for the hospital and that without the good relationship which existed between the sisters and Lucien Maynard, a member of the Manning's cabinet, that the Premier might not have come to the event.[1110]

The role of the EGH for the Franco-Albertan population of the Edmonton area

Generally, if one talks to Franco-Edmontonians, who are sixty and above, they refer to the EGH as *L'Hôpital Général* and as their hospital. They also often recall with nostalgia the days when many Grey Nuns worked at the hospital and when French was commonly heard in the corridors of the institution. An informal survey revealed the fact that they still consider the EGH as their hospital even if it has lost much of its French character and even if active treatment has been transferred to the new Grey Nuns' Hospital in the Millwoods neighbourhood.

[1106] Quote translation: "Our beautiful language is very much in danger in Alberta since the episcopal authority has become English." ASGME, Chroniques, 6 August 1927.

[1107] Ibid., 24 June 1946.

[1108] ASGME, Echo de la coline, Maison provinciale de Saint-Albert, January 1945.

[1109] A record number of 11 sisters went ot the 1936 meeting. ASGME, EGH, Chroniques, 1933 to 1960.

[1110] Ibid., June 1954.

The minutes of the medical staff meetings provided evidence which suggests that in the 1940s and 1950s the hospital treated many Franco-Albertans. For a number of years between 1942 and 1955, these minutes listed the surnames of patients who had passed away as well as the name of the physician who treated them.[1111] The data revealed that during these years, 246 (14,56%) of the 1689 patients who died at the EGH had French surnames. In addition, 197 (80.08%) of these 246 patients were treated by French Canadian physicians. Considering that Franco-Albertans comprised less than 10% of the population of Alberta, it may be suggested that even if the use of surnames is not an entirely reliable indicator of nationality, many Franco-Albertans died at the EGH. If one considers that the location of their death was linked to the fact that most French Canadian physicians worked at the EGH and that these people had selected the physician not necessarily the hospital, it remains that the EGH was the final institution where they received care. Logically, most of these patients were probably older individuals of the pioneering generations. It is thus possible, that having a francophone physician and being hospitalized at the EGH was more important to them than it was for their daughters or sons who had been raised in Alberta. Therefore, it is even more difficult to assess the degree to which these statistics were representative for the Franco-Albertan community as a whole. However, further evidence of the same era suggests that Franco-Albertans were attached to the EGH.

In 1945, the Grey Nuns were considering the option of transforming the St. Albert novitiate into an "English speaking novitiate". At the time, the Superior General communicated with the Oblates Provincial Superior who clearly stated that he was opposed to this project. He wrote:

[1111] ASGME, EGH, MMSM, 1942, and 1944 to 1955.

> Je ne crois pas que ce soit votre idée de faire de l'Alberta une province anglaise, mais déjà, nous avons lieu d'avoir des craintes. Sans parler de Saint-Albert, que dit-on de l'Hôpital Général? Pourtant cinquante pourcent des malades sont des canadiens-français et, à part les religieuses, la majorité des employés sont de langue anglaise; ce qui amène des protestations de part et d'autres. On entend dire que l'hôpital s'anglicise. Que ne dira-t-on pas, quand, du jour au lendemain, le noviciat de Saint-Albert deviendra anglais? Les canadiens français sont très éveillés en ce moment pour ne pas être profondément déçus, pour ne pas dire plus quand ce jour viendra.[1112]

A few weeks later the Superior General replied:

> Vos très sages observations sont l'écho de ma pensée. Nous avons du devoir nous rendre aux instances des Evêques de l'ouest - de son Excellence Mgr Monahan en particulier - mais dès le début de cette affaire, j'ai prévu les conséquences que vous signalez. Si mon conseil est de mon avis, nous maintiendrons le "status quo" tout en fournissant aux aspirantes anglaises par des mesures plus conciliantes au point de vue de la langue. Le tact et la psychologie devraient pouvoir accomoder les choses.[1113]

[1112] Quote translation: I doubt that it is your idea to transform Alberta into an English province, but already we have reasons to fear that this will happen. Without speaking about St. Albert, what are people saying about the EGH? Even if fifty percent of the patients are French Canadians, the sisters are about the only ones who speak French since the majority of the employees are English speaking, protestations do occur on both sides of the population [English and French]. We hear that the hospital is becoming increasingly English. What will be said, if over night, the novitiate of St. Albert becomes English? French Canadians are very sensitive at this moment, and they are already profoundly disappointed. What would happen the day the novitiate becomes English? Provincial Archives of Alberta, Oblates Collection, 72.220/1132, Letter of Father A. Boucher OMI Provincial to Mother Gallant, Superior General of the Grey Nuns' Order, Edmonton, 31 March 1945.

[1113] Quote translation: Your very wise observations are the echo of my own thoughts. The bishops of western Canada have been pressuring us - in particular his Excellency Bishop Monahan - but since the beginning, I have taken into account the consequences that you are mentioning. If my Council agrees we will maintain the "status quo", while

This correspondence suggests that the French population was concerned about the future of the EGH and obtaining hospital services in the French language was important to them. It also shows that the Irish episcopal authorities were pressuring the Grey Nuns to favour the English population which would have resulted in a net loss for Franco-Albertans.

This type of pressure was not new. Since the 1920's when an English speaking Bishop had been named, and the number of non-francophone Roman Catholics was rising, the sisters had to struggle to maintain the bilingual character of the hospital. Data presented about the nursing students' strike of 1929 showed that this conflict was related to the language question. Further evidence suggests that Archbishop MacDonald, who followed in the foot steps of Archbishop O'Leary, not only pressured the sisters about the novitiate but also about the EGH. In 1937, Mother Gallant wrote the Oblates Provincial Superior to inform him that Archbishop MacDonald wanted the EGH to be officially recognized as an English speaking institution.[1114] It may be suggested that the Grey Nuns had to appease the Archbishop by appointing an English speaking Superior of the EGH. In fact, it was noted that from 1940 to 1953, the hospital had two consecutive superiors who were not French Canadians. This was the only time this happened in the entire history of the EGH. The words of Dr. Louis-Philippe Mousseau at the opening of the hospital wing of 1953 suggest that tension existed.[1115] He stated: "Personne ici ne devrait s'étonner que j'adresse la parole en français, ce serait le contraire qui serait étrange, car l'oeuvre des Soeurs de la Charité des Territoires du Nord

---

we will make conciliatory provisions for English speaking candidates. Tactfulness and psychology should be sufficient to accommodate the situation. Ibid., Mother Gallant to Father Boucher, Montreal, 11 April 1945.

[1114] Ibid., 71.220/1130, Letter of Mother Gallant, Superior General to Father Ubald Langlois, OMI Provincial Superior, Montreal, 4 November 1937.

[1115] It is relevant to note that the bilingual invitations cards were sent to those invited. Chroniques, June 1953.

Ouest tel que son nom l'indique est une réalisation canadienne française."[1116] The fact that Dr. Mousseau took this stand his not surprising considering that he was actively involved in the ACFA. It may be suggested that if the EGH had not had supporters and physicians who wished to protect the French character of the institution it would have been more difficult to resist assimilation pressures.

In summary, it is evident that vigilance was needed to ensure that Franco-Albertans would continue to be provided with some hospital services in their mother tongue. Consumed as they were with educational issues, it may be stated that if the Grey Nuns and French Canadian physicians had not fought for them, French services would have entirely disappeared. The data presented in this chapter suggest that the Grey Nuns were aware of the precarious situation of Franco-Albertans and that like many French Canadians some of the sisters believed that language and faith were intricately bound with each other. Finally, as French Canadians the sisters socialized primarily with other French Canadians, and as expected their lives included active participation in typical French Canadian customs and celebrations.

[1116] Quote translation: No one here tonight should be astonished by the fact that I chose to speak in French, the opposite would be strange, as the name of incorporation names show *Les Soeurs de la Charité des Territoires du Nord Ouest* is a French Canadian accomplishment. ASGME, EHH, Doc. 252A. Paper of Dr. Louis-Philippe Mousseau presented at the opening of the 1953 wing.

CHAPTER 17

CONCLUSION

Five questions guided this historical study of the evolution of the Edmonton General Hospital. It is believed that the data presented and analyzed in this dissertation provides answers to these questions. The purpose of this chapter is to present general conclusions about the evolution of the EGH. This is done by revisiting the questions which were asked at the beginning of this investigation.

How did the role of nurses change at the EGH between 1895 and 1970?

Results of this study show that during the first thirteen years of operation, nursing care was exclusively provided by the sisters. By 1908, it became necessary to open a school of nursing primarily because the sisters were not numerous enough to meet the demands occasioned by the growth of the hospital. For similar reasons, by 1928 the sisters began to hire lay nurses. However, until the 1950s nursing students continued to constitute the largest portion of the nursing workforce. The data also show that by 1970, lay nurses provided most of the nursing care and were increasingly in charge of nursing units. During these last decades, nursing students were increasingly treated as students as opposed to hospital workers. It is thus evident that the nursing workforce was altered during the 76 years under investigation.

Data about the education of the nursing sisters showed that they were consistently more educated than most of the Canadian nurses who lived and worked during the same periods of time. The educational attainment of the sisters influenced the way in which nursing was delivered at the EGH and the manner in which they operated the school of nursing. It is evident from the data that the Grey Nuns were well informed, did not hesitate to follow new trends and were aware of the need to adapt nursing education to changing demands. In particular, the transfer of the school of nursing to a general educational system confirms that they wished to ensure that future students nurses would receive an education adapted to future exigencies. The history of the school of nursing also portrays how nursing curricula changed over time and how the teaching of nursing became increasingly controlled by nurses. As in other schools the of nursing, the first students of the EGH were taught primarily by physicians who gave modified versions of lectures, probably first written for medical students. In contrast, the students of 1970 received all nursing instruction from members of their future profession. Their nursing instructors transmitted to them nursing knowledge as well as relevant medical science concepts affecting the practice of nursing. In addition, a variety of specialists from the biological and social sciences also contributed to the education of the nursing students. As a whole the data on attrition and causes of attrition suggest that the school was typical and that the EGH students encountered the same difficulties as their colleagues from other regions or provinces of the country. Finally, it is important to note that the demographic information about nursing students revealed that the EGH school was an important provider of nursing education for students from almost all rural areas of Alberta and even to a large number young women from Saskatchewan. Thus, it may be stated that the EGH school was more than a local institution and was at least provincial if not regional in scope.

The delivery of nursing care was more complex in 1970 than it was in 1895. Advances made in medical science accounted for a large proportion of the changes which occurred during the period under investigation. In particular, it was shown that the post-WWII era was characterized by increasing delegation of medical acts to the nursing profession. Results presented in this study also show that the structure of the nursing service department was greatly modified in 1955 and in subsequent years. In general, it may be suggested that similar to what happened in other services of the hospital, the nursing department evolved from a small family like structure to a complex quasi-bureaucratic system. Data also showed that the working conditions and salaries of nurses improved significantly over time. However, it is clear that even by 1970, nurses received lower salaries than other members of the personnel (mostly men) who had inferior levels of education and lower qualifications. It is believed that this double standard and the fact that for many years marriage meant the end of employment for women created in large part the shortages of nurses which characterized the era. This alone, and the fairly regular questioning of the sisters' authority reflected widespread gender bias characterizing the society of the time.

Although nursing acquired new responsibilities which reflected the maturation of the profession, and the separation of the school of nursing from nursing service fostered the development of continuing education and of greater professional accountability, nursing never regained the stature it enjoyed at the beginning of the century. This certainly impacted negatively on the development of the profession. It must be recalled that in the 1890s and early 1900s, the sisters controlled the admission of patients and even welcomed some who did not require medical services, but rather nursing care. Evidence suggests that this practice gradually disappeared and was replaced by admission standards based on medical needs. Therefore, it may be suggested that the sisters eventually accepted that problems requiring medical attention were the only ones justifying admission. This loss was unfortunate both for patients and nurses since if the practice had not disappeared, the nurses of today may have been better positioned to embark upon independent practice. Related to this, it is important to recall that after 1908 and until around 1950, the hospital was primarily staffed by nursing students, a situation which did not favour professional autonomy since a very large part of the nursing workforce was comprised of students. Thus the situation was in sharp contrast with the earlier days of the hospital when the entire nursing staff was made up of sisters who had the ability to take on full responsibilities.

Finally, for almost the entire period of investigation the sisters were entirely in control of the nursing service administration as well as the overall management of the hospital. This situation was advantageous for nursing to the extent that the Hospital Superior and her Council were experienced nurses who could see the potential impact of change on the profession envisioned the adaptation skills required. The fact that the Superior was usually a nurse was advantageous for patient care, since she had a broad knowledge of the hospital world, and could be thus be a better patient advocate than the average administrator not possessing patient care related skills.

What was the impact of the Gey Nuns philosophy on patient care delivery and policy making at the EGH?

As Roman Catholic sisters, the Grey Nuns espoused the ethical principles of their church, and as owners and administrators of the EGH they ensured that Catholic morals were respected. It is clear however, that the Catholic nature of the hospital entailed much more than adherence to these principles. Evidence showed that the Grey Nuns's tradition of care was inherited from Mother d'Youville and that it was in direct line with the centuries old tradition of nursing brought to New France by French nursing sisterhoods. The Grey Nuns' philosophy of care was modeled on the religious beliefs of Mother d'Youville and on the importance she placed on charity. The results of this study show that the EGH sisters wanted to ensure that services were available to the less fortunate members of society. Evidence suggests that at times some of the physicians who practiced at the EGH were otherwise motivated. However, the sisters were vigilant and those who wished to transgress clearly defined boundaries were asked to leave. Providing a Roman Catholic atmosphere was of primary importance for the sisters and this explains in large part why their original feelings about the development of a national hospital insurance program were lukewarm. Their fear that state control would end their ability to offer religious services was understandable when considering the Catholic versus public school issues of earlier days.

The recognition of human beings as spiritual entities fashioned the sisters' philosophy of care and largely explains why they believed it was necessary to provide spiritual assistance to those who were sick. It is also explains why they considered that good care could not be provided without considering the person as a whole. As educators, the Grey Nuns transmitted this holistic vision to their nursing students and as administrators they made it clear that all personnel were to provide the type of care which arose from this philosophy. Finally, the Catholic nature of the hospital was also apparent in the manner in which the sisters reacted to the rise of collective bargaining. The sisters reaction to this new force was largely guided by the Catholic tenets of social justice. In general these tenets were laudable. However, the fact that gender bias was permitted, even encouraged, formed an inherent contradiction which had negative consequences for female workers. The double-standard was so accepted in society that the sisters were like other women of their time and did not seem to realize that women were treated unfairly.

What evidence is there of the impact of societal events on the EGH between 1895 and 1970?

Major social upheavals profoundly affected the hospital operations. For example, epidemics modified the routine of the hospital, the North American standardization movement had considerable impact, WWI brought additional income, WWII occasioned shortages of staff, the scientific advances and technologies developed during this war contributed to the establishment of new services in the 1950s and 1960s, and the nuclear threats of the cold war era led to the development of alert plans. The results of this study show that variations in the local and national economic climate directly affected the hospital. For example, in a number of instances the economic climate resulted in the postponement of construction and other expansion projects.

The economic depression of the 1930s surpassed all other events in the magnitude of its effect on the EGH. During these years the sisters showed determination and resourcefulness. By the end of the depression, financial difficulties appeared insurmountable, but the Grey Nuns successfully solved these by obtaining a series of tuberculosis contracts. The resulting large tuberculosis service altered the mission of the hospital, and significantly affected the School of Nursing. In particular, affiliation contracts had to be found for obstetrical experiences and potential students from Edmonton turned to other schools of the city. In addition, at the end of the depression, the unstable financial situation of the EGH rendered the Motherhouse lukewarm about the construction project proposed by the Edmonton sisters. Ensuing negotiations showed the extent to which the EGH sisters were determined to build and to give a new lease on life to their threatened hospital. This appeared to have been the only occasion in which the Motherhouse manifested great reluctance and hesitation in relation to the EGH plans. Results indicate that the Superior General and her Council were powerful allies who ensured that the Edmonton sisters could remain independent and masters in their own house. In particular, the Motherhouse oversaw the financial operations of a large network of hospitals and the combined assets of these institutions gave the Order the ability to borrow very large sums of money at favourable interest rates. The Grey Nuns' network was also important because it provided a means of communication by which the sisters were informed about innovations being made in the different parts of the country. Finally, it also provided a variety of opportunities which were used to develop the professional skills of the sisters. Thus, whenever a Grey Nuns' hospital established a new department or service, it was usually possible to involve a sister who already had expertise in the field. It is believed that this system significantly contributed to the quality of patient care found in Grey Nuns' institutions.

What changes at the EGH, between 1895 and 1970 can be attributed to the influence of federal and/or provincial government policies?

The results of this project show that the hospital was influenced by federal and provincial policies. Municipal policies also played a significant role especially during the first decades of operation. The events surrounding the creation of the Edmonton Public Hospital demonstrate that remaining independent and autonomous was a priority for the sisters and that these principles superseded financial considerations. The sisters were astute administrators who knew where to seek support, and how to take advantage of new policies. On a number of occasions the hospital coffers were replenished by offering services for which the provincial or federal government provided funding. The hospitalization of soldiers during both world wars and of tuberculosis patients are key examples of how the sisters capitalized on governmental measures.

However, as expected, it was after WWII that the impact of federal and provincial policy making was the most acutely felt. The development of a social safety net brought new contingencies which altered the Canadian hospital world. Significantly, these major changes also occurred when the advances made in medical science were leading to the emergence of new specialties and to the exponential growth of the workforce needed in laboratories and other support departments, and importantly at the time when it became increasingly difficult for the Grey Nuns and other sisterhoods to find new recruits. All these factors contributed to profound changes in the administrative structure of Catholic hospitals and of the EGH in particular. From a feminist perspective, the changes which took place in the Catholic hospitals during the 1960s were similar to those experienced in public hospitals at the turn of the century. In both cases women administrators were replaced by men resulting in a greater male dominance of the hospital world. Thus it may be suggested that if even though women made gains in their status in the 1960s, with the transition to an almost entirely public hospital system, they did not succeed in being appointed to key administrative positions. The effect was more marginal in Alberta than elsewhere in Canada. In Alberta there were many more public hospitals where the transition had already taken place, and many of the Catholic hospitals remained the property of the sisterhoods. However, at the national level, this change was of great magnitude especially because in Quebec religious orders had until then almost entirely controlled hospital services. Almost overnight, these sisterhoods almost entirely lost their authority over their institutions. The impact of this change on hospital care is difficult to assess. However, it may be suggested that the impersonal and business like atmosphere of the 1990s hospitals may well be linked to the minor presence of women in key administrative positions. Since in many cases women are more inclined to consider the human aspects of any given situations and since many of the key administrators would have been nurses if women had been freely appointed to such positions, directions taken might have been quite different if women had been a more integral part of the administrative system.

What were the effects on the hospital of the link between the Grey Nuns and the Franco-Albertan community?

There is no doubt that the EGH was influenced by the French Canadian heritage of the Grey Nuns and by the links which existed between the hospital and Franco-Albertans. The sisters had a French Canadian lifestyle, socialized primarily with other French Canadian sisters, and participated in Franco-Albertan festive events. The majority of the sisters were French Canadians and the close relationship which existed with the Motherhouse made the hospital very similar to Quebec institutions. The results of this study show that a number of Franco-Albertans worked at the hospital, that French speaking physicians were often in leadership positions, and that a significant number of nursing students were Franco-Albertans or French Canadians from bordering provinces. It is significant that when the sisters decided to transfer the School of Nursing to a mainstream educational institution they selected *Collège Saint-Jean*, the only bilingual college in Edmonton. Unfortunately, the change in status of *Collège Saint-Jean* resulted in the termination of a program that permitted Franco-Albertans who wanted to be nurses to receive at least part of their education in the French language. It does not seem that the Franco-Albertan community attempted to change this course of events and ironically, the reason was likely the time and energy required for the crusade for elementary and secondary school rights.

The sisters experienced difficulties related to their minority status and that these were regularly occasioned by Irish/French Canadian Catholic conflicts. These conflicts were national in scope, which shows the extent to which historical events rarely occur in isolation, but rather are played out over time and geographical locations. Protestant/Catholic rivalries also had an impact on the hospital especially at the turn of the century when the animosity between the two groups was particularly strong. However, these conflicts were magnified by the fact that most French Canadians were Roman Catholics while most English Canadians were Protestants and that each group had its own vision of what should become Canada.

In summary, this historical study of the evolution of the Edmonton General Hospital supports the position that a contextual approach is necessary to understand the development of a hospital and also that this development is influenced by a variety of social forces over time which often transcend local geographical boundaries. This phenomenon is evident when considering that the EGH was shaped by what could be called its multiple identities. The fact that the hospital was funded and operated by a French Canadian Roman Catholic nursing order from Quebec, and that it was located in Edmonton, Alberta, Canada, and North America contributed to its unique characteristics.

In closing some may be tempted to suggest that too much attention was given to the Grey Nuns in this study and in particular, that examining their social and cultural origins was marginally relevant to the history of a hospital. However, it can be argued that it is considered important to show that women, most of whom were nurses, who were of humble origins and members of a religious and cultural minority with all the inherent difficulties linked to these conditions, had the faith and fortitude necessary to surpass difficulties and contribute meaningfully to the health and well-being of their contemporaries. As human beings and as a caring and compassionate group of people the Grey Nuns were also the products of the society in which they lived. Like all other beings, they at times displayed the biases which characterized the eras in which they lived. What made them unique and very special is that they relentlessly tried to assist those in need. In the tormented hospital world of the 1990s, it might be timely for health care professionals, other hospital workers, and policy makers to reflect upon the values which motivated the Grey Nuns and profoundly influenced the history of the EGH from 1895 to 1970.

BIBLIOGRAPHY

Archival Material

Archives des Soeurs Grises de Montréal, Edmonton, (ASGME):

Edmonton General Hospital (EGH), File Names:

Anglais 1837.

Annual reports, 1913-1967.

Board of Directors, correspondence.

Board of Directors, papers.

Board of Managements, Minutes, 1970.

By-laws and moral code file.

By-laws and policies, 1940-1960.

Chroniques, 1895-1970.

Chronologie française.

Correspondence of the Assitant-Administrator.

Département des tuberculeux, 1932-1946.

Dossier des religieuses.

Edmonton Hôpital Historique, 1895-1970, Documents 1 to 256, (EHH), this collection consits primarily of letters and contracts.

Edmonton Hospital Agreements.

Edmonton Hospital Corporation, Sisters equity, 1968-1970.

Employés Hôpital Edmonton, 1949-1950 - Edmonton General Personnel policies.

Graduates in service: Edmonton, Statuts des infirmières graduées en servcie à l'Hôpital Général.

Histoire de l'école [des infirmières] 1908-1973.

Historique de l'école, 1908-1973, (EGHS).

History of the School of Nursing, (HSN).

Hôpital Edmonton, Visites canoniques, 1895-1953.

Hôpital Général, Finances, 1950-1958.

Hôpital Général, Livre de caisse, 1895-1939.

Liste des soeurs qui ont missionné à l'Hôpital Général d'Edmonton, 1895-1988.

Minutes of the Board of Directors, 1967-1969, (MBD).

Minutes of the Medical Executive Committee Meetings, 1933-1970, (MMEM).

Minutes of the Medical Staff Meetings, 1933-1970, (MMSM).

Nursing Procedures Manual, 1957.

Philosophy of function file.

School of Nursing, Sub-File Names:

Annual reports, 1955-56 to 1966-67.

Correspondence.

Minutes of the joint meetings of the two year program, 1967.

Première réunion des soeurs missionnaires dans nos hôpitaux de l'ouest, compte rendu des réunions de juillet 1917.

Registre des infirmières graduées, 1911-1973.

School bulletin, 1964.

General Documents:

Chroniques de l'Asile d'Youville de Saint-Albert, 1895-1915.

Circulaires mensuelles adressées aux diverses maisons de l'Institut.

Echo de la coline.

Holy Cross Hospital, Souvenir of the Golden Anniversary of the Holy Cross Hospital.

Lac Sainte-Anne historique.

Newspapers file, 1895-1970: La Survivance, L'Ouest Canadien, Le Franco, The Edmonton Bulletin, The Edmonton Journal and The Strathcona Plain Dealer.

Saint-Albert historique.

Archives des Soeurs Grises de Montréal, Montréal, (ASGM):

Lettres de Saint-Albert, 1858-1877.

Edmonton City Archives, (ECA):

Edmonton Public Hospital, Board Minutes, 1899-1939.

Population statistics.

Galt Museum and Archives, Lethbridge:

Newspaper collection of lethbridge Herald.

Medicine Hat Museum and Art Gallery Archives, Medicine Hat:

Collection of the Medicine Hat Hospital.

Provincial Archives of Alberta:

Oblates Collection, 72.220/1130, 72.220/1132.

University of Alberta Library, Government Documents Section:

Consolidated Ordinances of the Northwest Territories.

Statutes of Alberta, 1905-1970.

Books and Articles in Journals

Abercrombie, Sheila. ***Alberta Hospital Edmonton, 1923 to 1983. An outline of history to commemorate the 60th anniversary***. Edmonton: Alberta Hospital and ABC Press, 1983.

Agnew, G. Harvey. ***Canadian hospitals 1920-1970, a dramatic half century***. Toronto: University of Toronto Press, 1974.

Alberta Department of Health. ***Report of the nursing education survey committee, Province of Alberta, 1961-1963***. Edmonton: Queen's Printer, 1963.

Alberta Tourism. ***Province of Alberta official road map - 1986***. Edmonton: Author, 1985.

Allaire, Gratien. "Pour la survivance, l'Association Canadienne Française de l'Alberta." In ***Les outils de la francophonie***, 67-79. Winnipeg: Centre d'études franco-canadiennes de l'Ouest, 1988.

Allemang, Margaret. "Development of community health nursing in Canada." In ***Community health nursing in Canada***, ed. Miriam Stewart, Jean Innes, Sarah Searl, and Carol Smillie, 3-29. Toronto: Gage Educational Publishing Company, 1985.

Allen, Moyra. "Primary health care: research in action." In ***Recent advances in nursing, Primary care nursing***, ed. Lizbeth Hockey, 32-77. Edinburgh: Churchill Livingstone, 1983.

Anger, A. Ferland. ***Mère d'Youville - Première fondatrice canadienne***. Montreal: Librairie Beauchemin, 1945.

Ames, Herbert Brown. ***The city below the hill: a sociological study of a portion of the city of Montreal***. Montreal: Imprimerie Bishop, 1897.

Archer, John, H. "The Anglican Church and the Indians in the Northwest." ***Journal of the Canadian Church Historical Society***, 28 (April 1986): 19-30.

Bélanger, Diane, and Lucie Rozon. ***Les religieuses du Québec***. Montreal: Librairie Expression, 1982.

Berger, Carl. ***The writing of Canadian history, aspects of English-Canadian historical writing since 1900***. 2d ed. Toronto: University of Toronto Press, 1986.

Blishen, Bernard, B. "The construction and use of an occupational scale." ***The Canadian Journal of Economics and Political Science***, 18, 4 (1958): 519-531.

Bloch, Marc. ***The historian's craft***. Translated by Peter Putnam. Manchester: Manchester University Press, 1979.

Bourbeau, Robert, and Jacques Légaré. ***Evolution de la mortalité au Canada et au Québec, 1831-1931***. Montreal: Presses de l'Université de Montréal, 1982.

Bow, Malcom R. "The history of the department of public health of Alberta." ***Canadian Journal of Public Health***, 26 (August 1935): 384-396.

British Columbia Tourism. ***Official British Columbia road map - 1991***. Victoria: Author, 1991.

Brodie, Barbara. "The place of nursing in the development of medical care." ***Bulletin of the American Association for the History of Nursing***, (Spring 1991): 1-2.

Bureau fédéral de la statistique. ***Recensement des trois districts provisoires des territoires du Nord-Ouest 1884-1885***. Ottawa: Queen's Printer, 1886.

Camporesi, E.M., W.J. Greeley, P.D. Lumb and D.W. Watkins. "Anetshesia." In ***Textbook of surgery, the biological basis of modern surgical practice***, 13th ed., ed. David C. Sabiston, 158-177. Toronto: W.B. Saunders Company, 1986.

Canadian and American Automobile Association. ***Road map of Manitoba and Saskatchewan***. Heathrow, Florida: Author, 1990.

Canadian Nurses Association. ***A proposed curriculum for schools of nursing in Canada***. Montreal: Author, 1936.

Canadian Nurses Association. ***A supplement to a proposed curriculum for schools of nursing in Canada***. Montreal: Author, 1940.

Carrière, Gaston. "L'honorable Compagnie de la Baie d'Hudson et les missions dans l'ouest canadien." In ***The Canadian Catholic Historical Association, Report of 1965***, 63-80. Ottawa: The Canadian Catholic Historical Association, 1965.

Cashman, Tony. ***Heritage of service, the history of nursing in Alberta***. Edmonton: Alberta Association of Registered Nurses, 1966.

Castonguay, Thérèse. ***A mission of caring: Catholic Health Association of Alberta. A chronicle of the first fifty years***. Edmonton: Catholic Health Association of Alberta, 1991.

Cellard, André and Gérard Pelletier. ***L'histoire de l'Association Catholique Canadienne de la Santé - Fidèles à une mission***. Ottawa: Association Catholique Canadienne de la Santé, 1991.

Choquette, Robert. "Problèmes de moeurs et de discipline ecclésiastique: Les catholiques des prairies canadiennes de 1900 à 1930." ***Histoire sociale/Social history***, 8 (1950): 108-113.

Choquette, Robert. ***Language and religion. A history of English-French conflict in Ontario***. Ottawa: University of Ottawa Press, 1975.

Connor, J.T.H. "Hospital history in Canada and the United States." ***Canadian Bulletin of Medical History***, 7, 1 (1990): 93-104.

Conrad, Margaret. "The rebirth of Canada's past: a decade of women history." In ***Contemporary approaches to Canadian history***, ed. Carl Berger, 181-200. Toronto; Copp Clark Pitman Limited, 1987.

Conway, J.E. ***The west. The history of a region in confederation***. Toronto: James Lorimer and Company Publishers, 1984.

Copp, Terry. ***Classe ouvrière et pauvreté. Les conditions de vie des travailleurs montréalais, 1879-1929***. Montreal: Boréal Express, 1978.

Craig, Barbara Lazenby. "The Canadian hospitals in history and archives." ***Archivaria***, 21 (Winter 1985-1986), 52-67.

Cramer, Susan. "The nature of history: Meditations on Clio's craft." ***Nursing Research***, 41 (January 1992): 4 to 7.

Daigle, Joanne. "L'éveil syndical des 'religieuses laïques': l'émergence et l'évolution de l'Alliance des Infirmières de Montréal, 1946-1966." In ***Travailleuses et féministes - Les femmes dans la société québécoise***, ed. Marie Lavigne and Yolande Pinard, 115-138. Montreal: Boréal Express, 1983.

D'Allaire, Micheline. ***L'Hôpital Général de Québec, 1892-1764***. Montreal: Collection Fleur de Lys, Fides, 1971.

D'Allaire, Micheline. ***Vingt ans de crise chez les religieuses du Québec, 1960-1980***. Quebec: Editions Bergeron, 1983.

Department of Public Health of the Province of Alberta. ***History, administration, organization with work of the Provincial Department of Public Health and Board of Health***. Edmonton: Author, 1937.

Desjardins, Edouard, Suzanne Giroux, and Eileen Flanagan. ***Histoire de la profession infirmière au Québec***. Montreal: Association des Infirmières et Infirmiers de la Province de Québec, 1970.

Dickason, Olive P. "From 'One Nation' in the Northwest to 'New Nation' in the Northwest: A look at the emergence of the Métis." In ***The new people: Being and becoming Métis in North America***, ed. Jacqueline Peterson and Jennifer S.H. Brown, 20-71. Winnipeg: University of Manitoba Press, 1985.

Dominion Bureau of Statistics. ***Poliomyelitis trends***. Ottawa: Queen's Printer, 1957.

Dorward, Christina, and Olive Tookey. ***Below the flight path***. Edmonton: Commercial Printers Limited, 1968.

Ducharme, Alfred. ***Une dynamique communautaire de la foi - la communauté religieuse***. Montreal: Editions Bellarmin, 1982.

Dufrost, Charles. ***Mémoire pour servir la vie de madame d'Youville***. Quebec: n.p., n.d.

Dumont, Micheline and Michèle Jean, Marie Lavigne and Jennifer Stoddart. ***L'Histoire des femmes au Québec***. Louiseville: Imprimerie Gagné, 1982.

Dumont, Micheline and Michèle Jean, Marie Lavigne and Jennifer Stoddart, ***L'Histoire des femmes au Québec***. 2d ed. Louiseville: Imprimerie Gagné, 1992.

Dupont, Jean-Claude and Jacques Mathieu. ***Héritage de la francophonie canadienne, traditions orales***. Sainte-Foy, Québec: Presses de l'Université Laval, 1986.

Ell, Ann. ***Edmonton General Hospital, 90th anniversary publication***. Edmonton: Edmonton General Hospital, 1985.

Faillon, E.M. ***Vie de madame d'Youville - fondatrice des Soeurs de la Charité de Ville-Marie en Canada***. Paris: Périsse Frères, 1852.

Fauteux, Albina. ***Love spans the centuries***. Translated by Antoinette Bézaire. Montreal: Meridian Press, 1987.

Friesen, Gerald. ***The Canadian Prairies - A history***. Toronto: University of Toronto Press, 1984.

Frost, Elizabeth, A.M. "Introduction." In ***Post Anesthesia Care Unit, current practices***, 2d ed., ed. Elizabeth A.M. Frost, xix-xxi. Toronto: The C.V. Mosby Company, 1990.

Gahagan, Alvine Cyr. ***Yes Father, Pioneer nursing in Alberta***. Manchester, N.H.: Hammer Publications Inc., 1979.

Gibbon, John, M. and Mary S. Mathewson. ***Three centuries of Canadian nursing***. Toronto: The MacMillan Company of Canada, 1947.

Gilpin, John. ***The Misericordia Hospital, 85 years of service in Edmonton***. Edmonton: Misericordia Hospital, 1986.

Glaser, William A. ***Social setting and medical organization. A cross cultural-national study of the hospital***. New York: Atherton Press Inc., 1970.

Gottlieb, Laurie and Kathleen Rowat. "The McGill model of nursing: A practice derived model." Advances in Nursing Science, 9 (July 1987): 51-61.

Government of Canada. ***Report of the Royal Commission on Health Services***. Vol. I. Ottawa: Queen's Printer, 1964.

Granshaw, Lindsay. "Introduction." In ***The hospital in history***, ed. Roy Porter and Lindsay Granshaw, 1-19. New York: Routledge, 1989.

Grégoire, Paul. "Les religieuses dans la pastorale diocésaine." In ***La religieuse dans la cité***, 243-250. Montreal: Fides, 1968.

Guy, John, R. "Of the writing of hospital histories there is no end." ***Bulletin of the history of medicine***, 59 (1985): 415-420.

Hamelin, Jean. ***Histoire du Québec***. Montreal: Editions France-Amérique, 1977.

Hampton, Isabel Adams. ***Nursing: Its principles and practice***. 2d ed. Cleveland: E.C. Koeckert Publisher, 1905.

Harris, Robin, S. ***A history of higher education in Canada, 1663-1960***. Toronto: University of Toronto Press, 1976.

Hart, Edward, S. ***Ambitions et réalités, la communauté francophone d'Edmonton***. Translated by Guy Lacombe and Gratien Allaire. Edmonton: University of Alberta Press, 1981.

Henderson, Virginia. ***Principes fondamentaux des soins infirmiers***. Montreal: Association des Infirmières et Infirmiers de la province de Québec, 1960.

Huel, Raymond. "Gestae Dei Per Francos: The French Canadian experience in western Canada," in ***Visions of the new Jerusalem. Religious settlement on the prairies***, ed. Benjamin G. Smillie, 39-53. Edmonton: NeWest Press, 1983.

Irving, John, A. ***The social credit movement in Alberta***. Toronto: University of Toronto Press, 1959.

Jackel, Susan. ***A Flannel Shirt and Liberty. British Emigrant Gentlewomen in the Canadian West 1880-1914***. Vancouver: University of British Columbia Press, 1982.

Jamieson, Herbert, C. ***Early medicine in Alberta. The first seventy-five years***. Edmonton: The Douglas Printing Company Limited, 1947.

Juchereau, Jeanne-Françoise and Marie-Andrée Duplessis. ***Les annales de l'Hôtel-Dieu de Québec, 1636-1716***. Quebec: Hôtel-Dieu, 1939; reprint, Quebec: Hôtel-Dieu, 1984.

Kalish, Philip, A. and Beatrice J. Kalish. ***The advance of American nursing***. 2d ed. Boston: Little, Brown and Company, 1986.

Kerr, Janet Ross. "Educating nurses for the future." In ***Canadian Nursing Issues and Perspectives***, 2d ed., ed. Janet Ross Kerr and Jannetta MacPhail, 247-261. Toronto: Mosby Year Book, 1992.

Kerr, Janet Ross. "Emergence of nursing unions as a social force in Canada." In ***Canadian Nursing Issues and Perspectives***, 2d ed., ed. Janet Ross Kerr and Jannetta MacPhail, 209-320. Toronto: Mosby Year Book, 1992.

Kerr, Janet Ross. "Professionalization in Canadian nursing." In ***Canadian Nursing Issues and Perspectives***, 2d ed., ed. Janet Ross Kerr and Jannetta MacPhail, 24-31. Toronto: Mosby Year Book, 1992.

Kerr, Janet Ross. "The organization and financing of health care. Issues for nursing." In ***Canadian Nursing Issues and Perspectives***, 2d ed., ed. Janet Ross Kerr and Jannetta MacPhail, 168-188. Toronto: Mosby Year Book, 1992.

Kerr, Janet Ross. "The origins of nursing education in Canada. An overview of the emergence and growth of diploma programs 1874-1974." In ***Canadian Nursing Issues and Perspectives***, 2d ed., ed. Janet Ross Kerr and Jannetta MacPhail, 231-246. Toronto: Mosby Year Book, 1992.

Kravitz, Mona and Maureen A. Frey. "The Allen nursing model." In ***Conceptual models of nursing: analysis and application***, 2d ed., ed. Joyce Fitzaptrick and Ann Whall, 313-329. Norwalk, Connecticut: Appleton and Lange, 1989.

Lalonde, André. "Les canadiens français de l'ouest: espoirs, tragédies, incertitudes." In ***Du continent perdu à l'archipel retrouvé***, ed. R. Louder and Eric Waddell, 81-96. Quebec: Presses de l'Université Laval, 1983.

Laurin, Nicole, Danielle Juteau and Lorraine Duschene. ***A la recherche d'un monde oublié, les communautés religieuses de femmes au Québec de 1900 à 1970***. Montreal: Le Jour, 1991.

Legal, Emile. ***Règlements concernant couvents et hôpitaux. Extraits des règlements, usages, et discipline de l'archidiocèse d'Edmonton***. Quebec: n.p., 1916.

Lessard, Marc, and Jean-Paul Montminy. "The census of religious sisters of Canada." In ***Donum Dei II***, 273-401. Ottawa: A publication of the Canadian Religious Conference, 1966.

Ludmerer, Kenneth. "Writing the history of hospitals." ***Bulletin of the history of medicine***, 56 (1982): 106-109.

MacGregor, James. ***A history of Alberta***. Edmonton: Hurtig Publishers, 1972.

MacGregor, James. ***Edmonton, a history***. Edmonton: Hurtig Publishers, 1973.

MacInnis, C.M. ***In the shadow of the Rockies***. London: Rivingtons, 1930.

Macpherson, C.B. ***Democracy in Alberta: social credit and the party system***. 2d ed. Toronto: University of Toronto Press, 1962.

Maggs, Christopher, J. ***The origins of general nursing***. London: Croom Helms Editors, 1980.

Marsh, James H., ed. ***The Canadian encyclopedia***. Edmonton: Hurtig Publishers, 1985. S.v. "Armand Frappier", by Claude Vézina.

Matjecko, Joanna. "The Polish experiment in Alberta." In ***Peoples of Alberta - Portraits of cultural diversity***, ed. Howard Palmer and Tamara Palmer, 274-296. Saskatoon: Western Producer Prairie Books, 1985.

McGugan, Angus. ***The first fifty years. A history of the University of Alberta Hospitals 1914-1964***. Edmonton: The University of Alberta Hospitals, 1964.

Meleis, Afaf Ibrahim. ***Theoretical nursing, development and progress***. Philadelphia: J.B. Lippincott Company, 1985.

Mitchell, Estelle. ***Mère Slocombe, Neuvième supérieure générale des Soeurs Grises de Montréal***. Montreal: Fides, 1964.

Mitchell, Estelle. ***Les Soeurs Grises de Montréal à la Rivière Rouge, 1844-1984***. Montreal: Editions du Méridien, 1987.

Mondoux, Sister. ***L'Hôtel-Dieu premier hôpital de Montréal***. Montreal: Thériens Frères, 1942.

Morice, A.G. ***Histoire de l'église catholique dans l'ouest canadien (1659-1905)***. Vol. I. Montreal: Granger, 1912.

Morton, Arthur, S. ***A history of the Canadian West to 1870-1871***. 2d ed. Toronto: University of Toronto Press, 1973.

Morton, W.L. ***The progressive party in Canada***. Toronto: university of Toronto Press, 1950.

Mussallem, Helen, K. ***Spotlight on nursing education: The report of a pilot project for the evaluation of schools of nursing in Canada***. Ottawa: Canadian Nurses Association, 1960.

Mussallem, Helen, K. ***Nursing education in Canada - Royal Commission on Health Services***. Ottawa: Queen's Printer, 1965.

Nutting, Adelaide, and Lavinia Dock. ***A history of nursing***. New York: Putnam's Sons, 1907.

Owram, Doug. ***Promise of Eden. The Canadian expansionist movement and the idea of the west 1856-1900***. Toronto: University of Toronto Press, 1980.

Painchaud, Robert. "French Canadian historiography and Franco-Catholic settlement in western Canada, 1870-1915." ***Canadian Historical Review***, 59 (April 1978): 447-466.

Palmer, Howard. "Patterns of immigration and ethnic settlement in Alberta: 1890-1920." In ***Peoples of Alberta - Portraits of cultural diversity***, ed. Howard Palmer and Tamara Palmer, 1-49. Saskatoon: Western Producer Prairie Books, 1985.

Palmer, Howard, and Tamara Palmer. ***Alberta a new history***. Edmonton: Hurtig Publishers, 1990.

Perron, Normand. ***Un siècle de vie hospitalière au Québec, les Augustines de l'Hôtel-Dieu de Chicoutimi, 1884-1984***. Chicoutimi: Presses de l'Université du Québec, 1984.

Petitat, André. ***Les infirmières de la vocation à la profession***. Montreal: Boréal, 1989.

Reverby, Susan Mokotoff. ***Ordered to care. The dilemma of American nursing, 1850-1945***. Cambridge: Cambridge University Press, 1987.

Risse, Guenter, B. "Hospital history: new sources and methods." In ***Problems and methods in the history of medicine***, ed. Roy Porter and Andrew Wear, 175-203. London: Croom Helms Editors, 1987.

Rolph, William, Kirby. ***Henry Wise Wood of Alberta***. Toronto: University of Toronto Press, 1950.

Rosenberg, Charles, E. ***The care of strangers. The rise of America's hospital system***. New York: Basic Books Inc. Publishers, 1988.

Rosner, David. ***A once charitable enterprise. Hospitals and health care in Brooklyn and New York, 1885-1915***. Cambridge: Cambridge University Press, 1982.

Rousseau, François. ***L'oeuvre de chair en Nouvelle-France. Le régime des malades à l'Hôtel-Dieu de Québec***. Quebec: Cahiers d'histoire de l'Université Laval, Presses de l'Université Laval, 1983.

Sattin, Antoine. ***Vie de madame d'Youville***. Quebec: n.p., 1829.

Shanahan, Robert J. ***The history of the Catholic Hospital Association, 1915-1965, fifty years of progress***. St. Louis: The Catholic Hospital Associations of the United States and Canada, 1965.

Sharp, Paul. "The American farmer and the last best west." ***Agricultural history***, (April 1947): 65-75.

Sharp, Paul. ***The agrarian revolt in Western Canada. A survey showing American parallels***. Minneapolis, University of Minnesota Press, 1948.

Shillington, C. Howard. ***The road to medicare***. Toronto: Del Graphics Publishing Department, 1972.

Shortt, S.E.D. "The Canadian hospital in the nineteenth century: A historiographical lament." ***Journal of Canadian Studies***, 18, 4 (1983-1984): 3-14.

Silver, Arthur. I. ***The French Canadian idea of Confederation, 1864-1900***. Toronto: University of Toronto Press, 1982.

Smith, Donald. "A history of French-speaking Albertans." In ***Peoples of Alberta - Portraits of cultural diversity***, ed. Howard Palmer and Tamara Palmer, 84-108. Saskatoon: Western Producer Prairie Books, 1985.

Soeurs de la Charité de Montréal. ***Les Soeurs Grises***. Montreal: Author, 1987.

Soeurs Grises de Montréal. ***Institut Marguerite d'Youville, Publication du 25ième anniversaire***. Montreal: Séguin et Associés, 1960.

Stewart, Irene. ***These were our yesterdays. A history of district nursing in Alberta***. Calgary: Friesen Printers, 1979.

Street, Margaret. ***Watch-fires on the mountains: The life and writings of Ethel Johns***. Toronto: University of Toronto Press, 1973.

Swyripa, Frances. "The Ukrainians in Alberta." In ***Peoples of Alberta - Portraits of cultural diversity***, ed. Howard Palmer and Tamara Palmer, 214-242. Saskatoon: Western Producer Prairie Books, 1985.

Taylor, Elva. "Care of our Native Canadians." ***The Canadian Nurse***, 48 (February 1952): 123-125.

Taylor, Malcom, G. ***Health insurance and Canadian public policy. The seven decisions that created the Canadian health insurance system***. Montreal: McGill-Queen's University Press, 1978.

Taylor, Russell, F. ***A memorial to Russell Frederick Taylor - Polio' 53***. Edmonton: The University of Alberta Press, 1940.

Tessier, Yves. ***A l'ombre du Vatican. L'histoire des relations entre l'église canadienne et le Vatican de l'époque amérindienne à nos jours***. Quebec: Les Editions Tessier, 1962.

The Royal United Services Institute for Defense Studies. ***Nuclear attack and civil defence; aspects of civil defence in the nuclear age***. Toronto: Bronsey's Publishers Limited, 1982.

Thomas, Lewis, G. ***The liberal party in Alberta. A history of politics in the province of Alberta 1905-1921***. Toronto: University of Toronto Press, 1959.

Torrance, George, M. "Hospitals as health factories." In ***Health and Canadian society. Sociological perspectives***, 2d ed., ed. D. Coburn, C. D'Arcy, G. Torrance, and P. New, 479-500. Markham, Ontario: Fitzhenry and Whiteside, 1987.

Torrance, George, M. "Social-historical overview: the development of the Canadian health system." In ***Health and Canadian society. Sociological perspectives***, 2d ed., ed. D. Coburn, C. D'Arcy, G. Torrance, and P. New, 6-32. Markham, Ontario: Fitzhenry and Whiteside, 1987.

Trofimenkoff, Susan, M. ***Visions nationales. Une histoire du Québec***. Montreal: Edition du Trécarré, 1986.

Trottier, Alice. ***Jean-Baptiste Morin - Journal d'un colonisateur, 1890-1897***. Edmonton: Le salon de la francophonie albertaine, University of Alberta Press, 1984.

Van Kirk, Sylvia. ***"Many tender ties." Women in fur-trade society, 1670-1870***. Winnipeg: Watson and Dwyer Publishing Limited, 1980; reprint, Winnipeg: Watson and Dwyer Publishing Limited, 1986.

Vant, J. Ross, and Tony Cashman. ***More than a hospital, University of Alberta Hospitals 1906-1986***. Edmonton: University of Alberta Hospitals Board, 1986.

Vaticana. ***Cannonizzazione della Beata Marie Marguerite d'Youville***. [Canonization of the Beatified Marie Marguerite d'Youville]. Roma: Tipographia Poliglotta Vaticana, 1990.

Vogel, Morris. ***The invention of the modern hospital, Boston 1870-1930***. Chicago: University of Chicago Press, 1980.

Vogel, Morris. "Managing medicine: creating a profession of hospital administration in the United States, 1895-1915." In ***The hospital in history***, ed. Roy Porter and Lindsay Granshaw, 234-260. New York: Routledge, 1989.

Vogel, Virgile J. ***American Indian Medicine***. Norman, Oklahoma: University of Oklahoma Press, 1970.

Voisine, Nive. ***Histoire du catholicisme québécois***. Tome II. Montreal: Boréal Express, 1984.

Weir, George, M. ***Survey of nursing education in Canada***. Toronto: University of Toronto Press, 1932.

Wherrett, George. ***The miracle of the empty beds: a history of tuberculosis in Canada***. Toronto: University of Toronto Press, 1977.

Wilson, Betty. ***To teach this art. The history of the schools of nursing of the University of Alberta 1924-1974***. Edmonton: Hallamshire Publishers, 1977.

Young, David E. ***Cry of the eagle, Encounter with a Cree healer***. Toronto: University of Toronto Press, 1989.

Theses, Dissertations and Major Papers

Brown, Kenneth. "The evolution of hospital funding in Alberta." Health Services Administration major paper, University of Alberta, 1983.

Ell, Ann. "Edmonton General Hospital Research: 1895-1985." Unpublished paper, Grey Nuns Archives of Edmonton, 1985.

Collins, Paul, Victor. "The public health policies of the United Farmers of Alberta government, 1921-1935." M.A. thesis, University of Western Ontario, 1969.

Gagnon, Anne, C. "The Pensionnat Assomption: religious nationalism in a Franco-Albertan boarding school for girls, 1926-1960." Education Master's thesis, University of Alberta, 1988.

Glass, Helen, Preston. "Teaching behavior in the nursing laboratory in selected baccalaureate nursing programs in Canada." Ed.D. diss., Teachers College, Columbia University, 1971.

Hart, John, Edward. "The history of the French-speaking community of Edmonton, 1795-1935." M.A. thesis, University of Alberta, 1971.

Juzwishin, Donald. "A history, of the Alberta Hospital Association, 1919-1970." Health Services Administration Master's thesis, University of Alberta, 1980.

Kerr, Janet Ross. "Financing university nursing education in Canada: 191-1976." Ph.D. diss., The University of Michigan, 1978.

Létourneau, Marguerite. "Trends in basic diploma nursing programs within the provincial systems of education in Canada, 1964-1974." Ph.D. diss., University of Ottawa, 1975.

Maclean, Raymond, A. "The history of the Roman Catholic Church in Alberta." M.A. thesis, University of Alberta, 1958.

Myskiw, Joy, M.E. "The influence of the Alberta Association of Registered Nurses on health care services and health care policies from 1916-1950." Nursing Master's thesis, University of Alberta, 1992.

Power, Mary, Lucy. "Changes in ownership and executive structure in Canadian Roman Catholic Hospitals, 1858-1970." Health Services Administration major paper, University of Alberta, 1971.

Reverby, Susan Mokotoff. "The nursing disorder: A critical history of the hospital-nursing relationship 1860-1945." Ph.D. diss., Boston University Graduate School, 1982.

Swann, Richard, F. "Progressive social credit in Alberta 1935-1940." Ph.D. diss., University of Cincinnati, 1971.